

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a copy of the report will be furnished to the funeral director.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) REESE LOREE ADAMS			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 27, 1984			2b. HOUR 7:55 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 8 01		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Laborer		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Allegany County Nursing Home 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Reese					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-7089		17. INFORMANT ADDRESS Mrs. Margaret Bittner, Cumberland, Niece					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia 5990 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Pre-renal azotemia, dehydration, Left lower lobe									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2-16 , 19 84 , to 2-27 , 19 84 , that (I) (we) lost saw the deceased alive on 2-27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robustiano Barrera				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBUSTIANO BARRERA				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE 3-1-1984		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 20502				ADDRESS 20502		25a. DATE REC'D. BY REGISTRAR MAR 0 2 1984		25b. REGISTRAR'S SIGNATURE John Davidson Randall	

BP

1

RECEIVED
JAN 23 1964

State
Department
Washington, D.C.

Mr. [Name]

Dear Mr. [Name]:

Reference is made to your letter of [Date] regarding [Subject].

[The following text is extremely faint and largely illegible. It appears to be a multi-paragraph letter discussing administrative matters, possibly related to a passport or visa application. Key words that are faintly visible include "reference", "letter", "subject", "information", "please", "very", "sincerely", "Yours truly", and "Enclosure".]

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MD. 21502					
1. DECEASED NAME (TYPE OR PRINT) WILMA LOUISE ALDERTON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1984		2b. HOUR 8:45P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 6 1898	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper---		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Md	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 235 Paca Street 21502	
14. FATHER'S NAME FIRST MIDDLE LAST William Wentling			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216226421		17. INFORMANT ADDRESS James W. Alderton 6 Mt Vernon St Frostburg, Md 21532	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Stroke</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Long years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 84 2/15 84	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> 19 <u>84</u> , and that (I) (we) lost saw the deceased alive on <u>2/15</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. Espina</u>		DEGREE		22c. DATE SIGNED <u>2/16/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESPINA, RENATO, M.D.		22e. ADDRESS 907 SETON DRIVE, CUMBERLAND, MD, 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 18, 1984	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Maryland
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service, Cumberland, Md		ADDRESS 404 Decatur St		25a. DATE REC'D. BY REGISTRAR FEB 21 1984	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

STICK-HERBERT STREET
HON. DEARER STREET
CHICAGO, ILL.

WILMA LOUISE ALBERTSON

FEBRUARY 12, 1984

MILWAUKEE COUNTY

SACRED HEART HOSPITAL

RECORDED

1st Avenue
St. Luke
St. Luke's Hospital

St. Luke's
Hospital

1/12/84
2/12/84
2/12/84
2/12/84
2/12/84

ERIN, BERNARD, M.D.

903 E. 10TH STREET, CHICAGO, ILL. 60605

FEB 24 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

SCARPELLI FUNERAL HOME VIRGINIA AVE., CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.							
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
				FRANCES DOMINICA AMAN				FEBRUARY 14, 1984				10:20 A			
3. SEX				4. RACE				5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)			
Female				White				Dec. 11, 1915				68 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				USA								ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland				SACRED HEART HOSPITAL				Retired				Textile			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Allegany				Cumberland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				13e. STREET ADDRESS ZIP CODE				21502			
Frank Lisanti				Concetta Fragale				302 South Cedar St.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
no				214-07-4453				Mrs. George W. Aman, Cumberland, Husband							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon metastatic</u> 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>[Signature]</u>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2-16-84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
				BMG 912 SETON DRIVE, CUMBERLAND, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				2-17-1984				St. Marys Cemetery				Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR NAME				James F. Scarpelli, Cumberland, Md. 21502				FEB 21 1984				[Signature]			

STANDARD BANK OF
ATLANTA, GA.
CHARTERED 1845

FRANCIS FOR LICA AMAN FEBRUARY 19, 1984 10:00 A

Female 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

Unborn 1970 1000

Heavy 1970 1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03059

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARTHA JANE ANDRICK			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 10, 1984			2b. HOUR 4:05 M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1720 Frederick St. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Granville S. McDonald				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alzina E. Hood							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-38-5795		17. INFORMANT ADDRESS Jerry Andrick Star Route Flintstone, Md.							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>COPD with bilateral bronchiectasis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Chronic renal failure, pyelonephritis, pineal abscess, leukemia.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 23</u> , 19 <u>76</u> , to <u>Feb. 10</u> , 19 <u>1984</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u> MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/10/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ranjithan						22e. ADDRESS Memorial Hospital Medical Building Cumberland, Md. 21502					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 12, 1984		23c. NAME OF CEMETERY OR CREMATORY Maysville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Grant W. Va.			
24. FUNERAL DIRECTOR NAME Wendy N. Upchurch George-Upchurch Funeral Home				ADDRESS 202 Greene St. Cumberland, Md		25a. DATE REC'D. BY REGISTRAR FEB 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND FOR SCARPELLI FUNERAL HOME DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1- STATE REGISTRAR 108 VA. AVE. CUMBERLAND, MD				03060			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
JOHN LEMUEL ARBOGAST				FEBRUARY 2, 1984			
3. SEX Male				2b. HOUR 5:20 P.M.			
4. RACE White				6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS			
5. DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1908				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
7b. CITIZEN OF WHAT COUNTRY? USA				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Driver			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12b. KIND OF BUSINESS OR INDUSTRY Transit Co.			
13a. STATE Maryland				13b. CITY OR TOWN 104 South St. 21502			
13c. COUNTY Allegany				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST George L. Arbogast				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Ross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-10-7073			
17. INFORMANT ADDRESS Daughter Mrs. Gilda C. Stewart, Cumberland, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Carcinoma of Lung, Widely Metastatic				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-6, 19 84, to 2-2, 19 84, that (I) (we) lost saw the deceased alive on 2-2, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. Mazzocco M.D.				22c. DATE SIGNED 2-3-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE V. MAZZOCCO M.D.				22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-5-1984			
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR FEB 07 1984			
				25b. REGISTRAR'S SIGNATURE John J. Conner			

RECEIVED FROM THE
100 N. W. CORNER, BIRMINGHAM, ALA.

DATE: FEBRUARY 1, 1961
TIME: 2:30 P.

TO: ALLIANCE COUNTY
FROM: [illegible]

SUBJECT: [illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

RECEIVED FROM THE
FEBRUARY 1, 1961
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

MARKWOOD FUNERAL HOME 1. FOR STATE REGISTRAR 211 MINERAL STREET KEYSER, WV. Item 13b 3-7-84 cn				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				03061 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CECIL ALBERT BAILEY				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1984				2b. HOUR 8:55AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Shovel Operator		12b. KIND OF BUSINESS OR INDUSTRY Mining			
13a. STATE Maryland				13b. COUNTY Mineral		13c. CITY OR TOWN Mc Coole		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Burkes Hill 26726	
14. FATHER'S NAME FIRST MIDDLE LAST Albert L. Bailey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Matthews							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 526141152		17. INFORMANT ADDRESS Himself, Markwood Funeral Home Records Keyser, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> 4413 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-24 hrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Previous episode of aortic aneurysm suggested</u>											
19a. DATE OF OPERATION 2/27/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal aortic aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>84</u> , to <u>2/28</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Philip Schroeder</u>				DEGREE M.D.				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCHROEDER, PHILIP MD.				22e. ADDRESS P.O. BOX 2455, CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/1/84		23c. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens, Keyser, Mineral, W. Va.				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <u>Harold W. Keyser</u>				ADDRESS W. Va. Markwood Funeral Home, 111 S. Mineral St. Keyser				25a. DATE REC'D. BY REGISTRAR MAR 05 1984			
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>							

BP _____

2-22-50

FEBRUARY 22, 1950

ALBERT BAILEY

CECIL

15

NOV. 20, 1950

MISS

MISS

ALLIANCE COUNTY

MISS

MISS

MISSING

MISSING

SACRED HEART HOSPITAL

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

MISSING

P.O. BOX 222, CLEVELAND, OHIO 22

SCHROEDER, PHILIP H.

MISSING

MISSING

MISSING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1- FOR STATE REGISTRAR DURST FUNERAL HOME 27 FROST AVE. FROSTBURG, MD 21532				3062	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETSY ELLEN BAMPTON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21, 1984		2b. HOUR 11:45A _M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 13, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY PAPER CO.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN MIDLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES BAMPTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MC KEE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-07-9344		17. INFORMANT ADDRESS RAYMOND BAMPTON, MIDLAND, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>cardiomyopathy</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 mo 10 yrs
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 21, 1984, to Feb 21, 1984, that (I) (we) last saw the deceased alive on Feb 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald M. Manger, M.D.		DEGREE		22c. DATE SIGNED 21 Feb 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANGER, DONALD M.D.		22e. ADDRESS 55 JACKSON ST. LONA CONING, MD 21539		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK FROSTBURG, ALLEGANY, MD.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR FEB 29 1984			
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD.		25. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

DIRECT BUREAU HOME, PROCTOR, MD. FEB 29 1961
 BUREAU FEB. 29 1961 PROCTOR, MD. PAUL PROCTOR, ALBANY, NY.

MANGER, DONALD M.D. 77 WACHSON ST. LYNN, MASS.

NO 025-07-0281 RAYMOND BARTON, MIDLAND, MARYLAND

JAMES BARTON MIDLAND MARY

MIDLAND ALBANY MIDLAND X MIDLAND BROAD STREET

BROAD STREET SECRETARY PARKER CO.

U.S.A. ALBANY COUNTY X

NOV. 13, 1901 79

FEBRUARY 27, 1901 BARTON

WEST BUREAU HOME, PROCTOR, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35
32
35
10
1

EICHORN FUNERAL HOME MAIN STREET LONA CONING, MD 21539				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. FOR STATE REGISTRAR				REG. NO. 03063			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
ALEXANDER NMI BARCLAY				FEBRUARY 14, 1984			
3. SEX Male				2b. HOUR 4:10 AM			
4. RACE White				6. AGE (IN YEARS LAST BIRTHDAY) 68			
5. DATE OF BIRTH MONTH DAY YEAR Oct 22 1915				7. IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN) Md				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
7b. CITIZEN OF WHAT COUNTRY? USA				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HSOPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Celanese				12b. NAME OF EMPLOYER OR INDUSTRY Corp.			
13a. STATE Md				13b. CITY OR TOWN Lonaconing			
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13d. STREET ADDRESS / ZIP CODE 17 Watercliff St. 21539			
14. FATHER'S NAME Alexander MIDDLE Barclay				15. MOTHER'S MAIDEN NAME Veronica Garlitz MIDDLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II				16b. SOCIAL SECURITY NO. 217-10-6094			
17. INFORMANT Nola J. Barclay				ADDRESS Lonaconing, Md. 17 Watercliff			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) sepsis				5 days			
DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia				6 days			
DUE TO, OR AS A CONSEQUENCE OF (c) renal failure				3 mns			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Hypertensive cardiovascular disease							
19a. DATE OF OPERATION 1/16/84				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DD bleeding			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10:31, 1983, to 1:30 PM, 1984, that (I) (we) last saw the deceased alive on 13 Feb 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald Manger				22c. DATE SIGNED 14 Feb 84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD D. MANGER, MD				22e. ADDRESS 55 JACKSON STREET, LONA CONING, MD 21539			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 16, 1984			
23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park				23d. LOCATION Cumberland Allegany ST. MD.			
24. FUNERAL DIRECTOR George A. Eichhorn				25a. DATE REC'D. BY REGISTRAR FEB 21 1984			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

BP

1000-1000
1000-1000
1000-1000

ALWAYS
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

1000-1000
1000-1000
1000-1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03064	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Carrie A. Bean						2a. DATE KNOWN OF DEATH ESTIMATED XX 2-9-1984		2b. HOUR 5:30am			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 1896		6. AGE (IN YEARS) LAST BIRTHDAY 87 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 2 9 1984 10a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		
10. CITY OR TOWN OF DEATH Barton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY Housework		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Barton						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS Box 225 Barton Md.					
14. FATHER'S NAME FIRST Robert MIDDLE Moffatt LAST Moffatt						15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE Soubrien LAST Soubrien					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) n				16b. SOCIAL SECURITY NO. 212-03-5977		17. INFORMANT ADDRESS Mr. Jack Bean Barton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Giovanni Mastrangelo M.D.						TITLE (SPECIFY) _____ MEDICAL EXAMINER			DATE SIGNED _____		
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.						ADDRESS 900 Seton Drive, Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/11/84		23c. NAME OF CEMETERY OR CREMATORY St. Gabriels Cemetery			23d. LOCATION CITY OR TOWN Barton COUNTY Allegany STATE Maryland			
24. FUNERAL DIRECTOR NAME Walter Coal ADDRESS Baals Funeral Service Westport, Md.						25a. RECEIVED BY REGISTRAR FEB 15 1984			25b. REGISTRAR'S SIGNATURE Sha Davidson-Randall		

BP

1950

1950

1950

1950

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be buried with the body after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03065

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lester Albert Bender			2a. DATE OF DEATH MONTH DAY YEAR 2/26/84			2b. HOUR 6:15am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/23/99		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. 84		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Comm Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GUARD		12b. KIND OF BUSINESS OR INDUSTRY HOUSE OF CORRECTION	
13a. STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4301 DUANE AVE. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT BENDER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE PENGELLY			ADDRESS FROSTBURG, MD. 21532			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A.		17. INFORMANT MR. RALPH BENDER		ADDRESS 5 STANDISH ST.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 Cardio Respiratory ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Insufficiency & Uremia DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonitis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 22 , 19 84 , to Feb. 26 , 19 84 , that (I) (we) last saw the deceased alive on Feb. 25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Chang M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Chang				22e. ADDRESS Frostburg, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/28/84		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ECKHART ALLEGANY MD.			
24. FUNERAL DIRECTOR M. Sowers				60 W. MAIN ST. ADDRESS Sowers, Frostburg, Md		25a. DATE REC'D. BY REGISTRAR MAR 05 1984		25b. REGISTRAR'S SIGNATURE Alia Davidson-Randall	

BP

RECEIVED
JAN 10 1964

5



BALTIMORE

AND AT

SEND TO

QUIN HINN

YANKEE

100-100000

100-100000

100-100000

100-100000



RECEIVED
JAN 10 1964
MAR 10 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MILDRED GERTRUDE BOOR			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 12, 1984			2b. HOUR 11:00 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 8, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL SUCH FACILITY AND STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 1, Box 179A 21545	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Marks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alta Marie Heasley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-48-7668		17. INFORMANT ADDRESS Son Mr. Earl E. Boor, Route 4, Meyersdale, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 Cardiac Arrest IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Old. atherosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Bilateral pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-16 , 19 84 , to 2-12 , 19 84 , that (I) (we) lost saw the deceased alive on 2-12 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William P. James				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William P. James				22e. ADDRESS 441 N. Centre St. cumberland, Maryland 21502					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 2-15-1984		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 21 1984 [Signature]					

must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

SCARPELLI FUNERAL HOME				STATE OF MARYLAND	
108 VIRGINIA AVE.,				DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
1 - STATE REGISTRAR CUMBERLAND, MD 21502				CERTIFICATE OF DEATH	
REG. NO.				03067	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE CATHERINE LAST BOWMAN			2a. DATE OF DEATH MONTH FEBRUARY DAY 29, YEAR 1984		2b. HOUR 6:45 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY In Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 939 Gay St. 21502		
14. FATHER'S NAME FIRST Paul F. MIDDLE Lechliter LAST		15. MOTHER'S MAIDEN NAME FIRST Mary Catherine MIDDLE Harbaugh LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-34-4900		17. INFORMANT ADDRESS Mr. Kenneth L. Bowman, Cumberland, Husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) UGT Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal Varices. DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of the liver					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-7-1984, to 2-29-1984, that (I) (we) lost saw the deceased alive on 2-28-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MEHANNA K.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-29-84	
22d. PRINT NAME OF PHYSICIAN (TYPE OR PRINT) JOHN B. MEHANNA, MD		22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-3-1984	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR MAR 06 1984			
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.					
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) Myrle M. Bragg					2a. DATE OF DEATH MONTH DAY YEAR 02 07 84					
3 SEX female					2b. HOUR 13:06 M					
4 RACE white					5. DATE OF BIRTH MONTH DAY YEAR 11 15 1902					
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.					7. BALTIMORE CITY OR COUNTY OF DEATH Allagany Co.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH Cumberland					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital (DOA)					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE WV					13b. COUNTY Mineral					
13c. CITY OR TOWN Ridgeley					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
13e. STREET ADDRESS / ZIP CODE 51 Blocker St. 26753 99999										
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.					16b. SOCIAL SECURITY NO. 220-10-1857					
17. INFORMANT Mr. George R. Dixon					ADDRESS P.O. Box 24 Ridgeley, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 4140 IMMEDIATE CAUSE (a) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-7-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 2/8/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25. DATE REC'D. BY REGISTRAR FEB 10 1984		25. REGISTRAR'S SIGNATURE [Signature]	

13:02

02

13:02

13:02

01

13:02

13:02

13:02

13:02

13:02

13:02

13:02

13:02

13:02

13:02

13:02

13:02

13:02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

FOR Item 13athru e 3-7-84										STATE OF MARYLAND																																																	
1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE																																																	
CERTIFICATE OF DEATH										REG. NO.																																																	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR																																							
FRANK JAMES BROWN, V										FEBRUARY 28, 1984										11:08 A																																							
3. SEX										4. RACE										5. DATE OF BIRTH MONTH DAY YEAR										6. AGE (IN YEARS LAST BIRTHDAY)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Male										White										Feb 28 1984										0 YRS.										2										52									
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH										12b. KIND OF BUSINESS OR INDUSTRY																			
Maryland										U.S.A.																				Allegany										MD																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																													
CUMBERLAND										MEMORIAL HOSPITAL																																																	
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS / ZIP CODE																			
Md										Allegany										Cumberland										YES <input type="checkbox"/> NO <input type="checkbox"/>										1026 Shades Lane 21502																			
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																																																	
Frank J Brown IV										Lori Ann Williams																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS										1026 Shades Lane Cumberland, Md 21502																													
																				Frank J. Brown IV																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dysplastic lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Potter Syndrome c Agnesis of both kidney</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
7530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>84</u> , to <u>2-28</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <u>Rohallah Moainie MD</u> DEGREE										22c. DATE SIGNED <u>2/29/84</u>																																																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. MOAINIE</u>										22e. ADDRESS <u>900 Seton Drive Cumberland, Md. 21502</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>										23b. DATE <u>Mar 1, 1984</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Mem Gardens</u>										23d. LOCATION CITY OR TOWN COUNTY STATE <u>LaVale Allegany Maryland</u>																													
24. FUNERAL DIRECTOR NAME <u>Silcox-Merritt Funeral Service, Cumberland, Md</u> ADDRESS <u>404 Decatur St</u>										25a. DATE REC'D. BY REGISTRAR <u>MAR 05 1984</u>										25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>																																							

1991 3070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03070	
1. DECEASED NAME (TYPE OR PRINT) RICHARD JOHNSON BRUCE, SR.			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1984		2b. HOUR 10 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 30, 1913	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 115 Karns Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Traffic Supr.		12b. KIND OF BUSINESS OR INDUSTRY Celanese
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Motter Bruce			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Roberts		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W.11 214-07-6764	17. INFORMANT ADDRESS Richard Bruce, Jr.-Cumberland, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>HEP</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u> <u>YES</u> <u>YES</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (the physician) attended the deceased from <u>1984</u> , 19 <u>84</u> , to <u>2/6</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2/5</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Bruce P. Benson, M.D.</u>		DEGREE MD		22c. DATE SIGNED 2/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce P. Benson, M.D.		22e. ADDRESS Benson Red Group			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/9/84		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-Md.					
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502		25a. DATE REC'D. BY REGISTRAR FEB 17 1984			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

93071

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
HERBERT BUEHLER BUCKEL		Feb. 4 19 84		9:55 AM	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
M	W	2 28 07	76 RS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cumberland		Memorial Hospital		Farmer	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Garrett		Bittinger	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Oliver C. Buckel		Ruth M. Shoup		215-36-9950	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b. INFORMANT		17c. STREET ADDRESS	
No		Lenora W. Buckel, Bittinger, MD		21522	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) 4472		Bleeding Diathesis as a post-surgical		16 hours after surgery	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) complication for repair of a bleeding			
		(c) Aorto-Duodenal fistula.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
2-3-84		Bleeding aorto-duodenal fistula		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Francisco Reyes		M.D. Deputy		2-4-84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Dr. Francisco Reyes		900 Seton Drive, Cumberland, MD		21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 6, 1984		Bittinger Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
M. Lynn Neuman		FEB 8 1984		John J. [Signature]	
ADDRESS		CITY OR TOWN		COUNTY STATE	
Grantsville, Md.		Bittinger, Garrett, Md.			

Handwritten signature

888 8888

100,000,000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CUMBERLAND, MD. 21502

1- FOR STATE REGISTRAR

202 GREEN STREET
CUMBERLAND, MD. 21502

CERTIFICATE OF DEATH

REG. NO. 03072

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE L LAST CAMPBELL			2a. DATE OF DEATH MONTH FEBRUARY DAY 9, YEAR 1984		2b. HOUR 22:07R
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Jan. DAY 20, YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE W. Va. COUNTY Mineral CITY OR TOWN Ridgeley			13b. STREET ADDRESS / ZIP CODE Carpenter's Addition 26753		
14. FATHER'S NAME FIRST James MIDDLE F. LAST Kyte		15. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE L. LAST Hammer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 235-72-0860		17. INFORMANT ADDRESS 10 Silver St. John F. Campbell Ridgeley, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiac arrest - DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarct, A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF (c) Marked atherosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Co d color by Hx					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-28-84, to 2-9-84, that (I) (we) last saw the deceased alive on 2-9-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Mehanua M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-10-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN MEHANUA, M.D.		22e. ADDRESS 909-B SETON DR., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 12, 1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.		23e. DATE REC'D BY REGISTRAR FEB 17 1984			
24. FUNERAL DIRECTOR NAME Wendy N. Upchurch 202 Greene St. George-Upchurch Funeral Home Cumb., Md. 21502		25. REGISTRAR'S SIGNATURE John Davidson-Randall			

BRIDGE & STREET, FIVE FIVE
 203 GREEN STREET
 CHICAGO, ILL. 60601

James	F.	Kyle	Edna	L.	James
No	22-23-24	John F. Campbell	Richard, W. W.	10 South St.	James
W. W.	Honored	Widow	X	Carroll's Addition 20755	Honored
Commandant	SACRED HEART HOSPITAL	Honored			Honored
Widow	W. S. A.	X		ALLIANCE CITY	
James	James	James	James	James	James

James
 Feb. 12, 1934 James W. W.
 203 Green Street
 Chicago, Ill. 60601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 03073				
1. DECEASED NAME (TYPE OR PRINT) ROBERT VERNON COFFMAN					2a. DATE OF DEATH MONTH DAY YEAR February 3, 1984			2b. HOUR 9:20 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 8 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. STATE W.Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 113 26726	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Coffman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Mae McNemar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 723-07-8917		17. INFORMANT ADDRESS Robert V. Coffman Rt. 2, Box 113, W.Va. Keyser					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute MI 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) waterslides CA lung DUE TO, OR AS A CONSEQUENCE OF (c) + atherosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 84 , to 2/3 19 84 , that (I) (we) last saw the deceased alive on 2/3 19 84 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thaddeus Elder		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thaddeus Elder				22e. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gards.		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale Allegany Md.			
24. FUNERAL DIRECTOR Markwood Funeral Home				ADDRESS Keyser, W.Va. 111 S. Mineral St		25a. DATE REC'D. BY REGISTRAR Feb 8 1984		25b. REGISTRAR'S SIGNATURE John J. Smith	

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03074

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM LEE COOK			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 2, 1984			2b. HOUR 9:45 A. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Foreman	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Franklin Cook		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Stuiber		13e. STREET ADDRESS / ZIP CODE 414 Magruder St. 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) War I 705-09-5243		17. INFORMANT ADDRESS Mrs. Mina May Cook, Cumberland, Md. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c) Arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Myocardial Infarction							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days green
19a. DATE OF OPERATION 2-3-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Myocardial Infarction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
22a. I certify that (I) (this hospital) attended the deceased from 1-26 , 19 84 , to 2-2 , 19 84 , that (I) (we) last saw the deceased alive on 2-3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William P. Iames				DEGREE Attending Physician		22c. DATE SIGNED 2/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM P. IAMES				22e. ADDRESS W. Centre St. Cumberland, Maryland 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-5-1984		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Davis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

11BCE

POW

20%

11/11

[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Some words like "POW" and "11/11" are visible.]

GEORGE-UPCHURCH FUNERAL HOME STATE OF MARYLAND
202 GREENE STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ADWIN CUPLER, II			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1984		2b. HOUR 3:17P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 4, 1912	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President-National Jet Company		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN LaVale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edwin Howard Cupler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen --- Kelleher		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-1475		17. INFORMANT ADDRESS John A. Cupler, Jr. Garrett County Farm Grantsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) Metastatic Prostate Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 18, 1984 to Feb 23, 1984 , that (I) (we) lost saw the deceased alive on Feb 23, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul Livengood MD		DEGREE		22c. DATE SIGNED Feb 24, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL LIVENGOD, M.D.		22e. ADDRESS BMG-912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/26/84	23c. NAME OF CEMETERY OR CREMATORY Cupler Family Pvt. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale Allegany Co. Md.
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.			25a. DATE REC'D BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE Handell

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03076

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERMA M DEVORE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16, 1984		2b. HOUR 1:30 A M		
1.5 EX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (IF NOT USUAL, GIVE NATURE OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Ellerslie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Melvin Bowman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aleatha Riggleson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-86-3206		17. INFORMANT ADDRESS Mr. Vernon J. De Vore, Ellerslie, Md. Husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4148 Congestive Cardiac failure, Infarctable</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Diabetes, Renal failure, peripheral vascular disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ranjithan</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANJITHAN		22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-19-1984		23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Near Ellerslie, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR FEB 23 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03077

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank F. Dilfer			2a. DATE OF DEATH MONTH DAY YEAR 2/22/84			2b. HOUR 11:15 ^A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany ^{MD}			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Cumberland Nursing Home Ret. Paper Worker				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) West Vaco		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD Allegany Lonaconing			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. STREET ADDRESS 3 Island St. Lonaconing, Md. 21539			
14. FATHER'S NAME FIRST MIDDLE LAST John Dilfer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Nicol			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (NONE OR UNKNOWN) None			
16a. SOCIAL SECURITY NO. 216-07-4035			17. INFORMANT Mrs. Louise Turnbull			ADDRESS Granlich Rd. La Vale, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4940

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) **Chronic Obstructive Pulmonary Disease, advanced.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Malfunctioning Aortic Valve Prosthesis. Permanent Pacemaker. Bronchiectasis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/16/1984 , 19____, to 2/21/84 , 19____, that (I) (we) lost saw the deceased alive on 2-21-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE N. P. SATHA ^{MD}				DEGREE MD		22c. DATE SIGNED Feb. 23, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. P. SATHA				22e. ADDRESS Memorial Hosp. Cumberland Md 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION Cumberland Allegany Md	
24. FUNERAL DIRECTOR NAME ADDRESS George D. Eichhorn 85. MAIN ST. Lonaconing, Md				25a. DATE REC'D. BY REGISTRAR FEB 27		25b. REGISTRAR'S SIGNATURE John Davidson	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

11:15

3/25/81

Frank E. Miller

Life

1981

Life

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

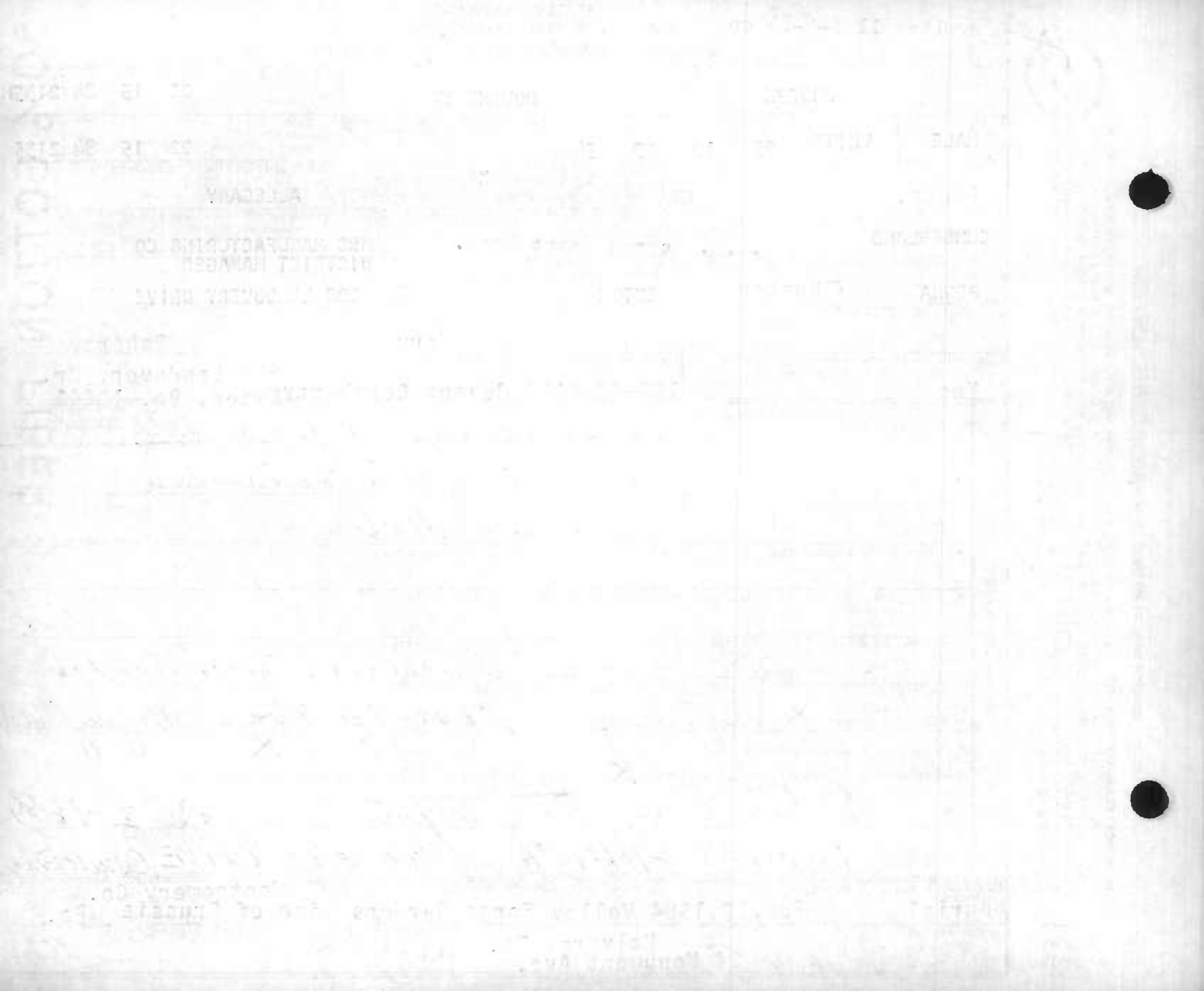
1981

1981

1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOSEPH DOUGHERTY						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 02 15 19 84 2b. HOUR 2135H					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 03 DAY 10 YEAR 29		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D.O.A. Scared Heart Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MRS MANUFACTURING CO			
13a. STATE PENNA				13b. COUNTY Chester		13c. CITY OR TOWN EXTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 200 LANDOVERY DRIVE 99999	
14. FATHER'S NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/>						15. MOTHER'S MAIDEN NAME FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/> Mary Doherty					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 183-20-8169		17. INFORMANT ADDRESS 200 Landoverly Dr. Exton, Pa. 19341					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure - Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8129 (b) Severe Trauma to Head and neck DUE TO, OR AS A CONSEQUENCE OF (c) Auto Accident APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 35 A.M. 2 15 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto accident in tractor-trailer.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway				21f. LOCATION STREET Rt 48 - Flintstone CITY OR TOWN Allegany COUNTY Mad STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquest <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Nicholas Giarritta				TITLE (SPECIFY) Deputy M.D.				MEDICAL EXAMINER DATE SIGNED 2-16-84			
EXAMINER'S NAME (TYPE OR PRINT) NICHOLAS GIARRITTA				ADDRESS 900 SETON DRIVE CUMBERLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 18, 1984		23c. NAME OF CEMETERY OR CREMATORY Valley Forge Gardens King of Prussia, Pa.				23d. LOCATION CITY OR TOWN Montgomery Co. STATE Pa.	
24. FUNERAL DIRECTOR NAME George Land				ADDRESS 24 Monument Ave. Malvern, Pa.				25a. DATE REC'D BY REGISTRAR FEB 24 1984		25b. REGISTRAR'S SIGNATURE	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										2a. DATE OF DEATH	
DECEASED NAME (TYPE OR PRINT) Joseph T. Downey										KNOWN <input type="checkbox"/> MONTH DAY YEAR ESTIMATED <input checked="" type="checkbox"/> 2/21/84	
SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 2/21/84	
10. CITY OR TOWN OF DEATH Frostburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5 Barnard Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY County	
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Barnard Street	
14. FATHER'S NAME FIRST MIDDLE LAST William W. Downey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mayno Huffman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-38-5422		17. INFORMANT ADDRESS Joel T. Downey, Pittsburgh, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic Heart Disease IMMEDIATE CAUSE (a) 4/40 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Giovanni Mastrangelo				TITLE (SPECIFY) Deputy M.D.				DATE SIGNED 2/22/84			
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo				ADDRESS Sacred Heart Hosp., Cumberland Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 23 '84		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.			
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.				ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 29 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Randall			

Joseph W. Henry

Male White Aug. 23, 1908 77

Maryland U.S.A. X Allegany

Thompson 2 Barnard Street Supervisor County

Maryland Allegany X 2 Barnard Street

William W. Henry
No 212-38-1112 Joel W. Henry, Pittsburgh, Pa.
Hillman 1025 Hillman Ave.
Hillman

Large number of home, Washington, D.C. 1882 29 204
Hillman 1025 Hillman Ave. Hillman, D.C.
Hillman 1025 Hillman Ave. Hillman, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

SOWERS FUNERAL HOME				STATE OF MARYLAND	
1- FOR STATE REGISTRAR 60 W. MAIN ST. FROSTBURG, MD 21532				DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
				CERTIFICATE OF DEATH	
				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE M DOWNTON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1984		2b. HOUR 11:32 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12/6/38		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS AND ADMISSION) 13a. STATE MARYLAND			13b. COUNTY ALLEGANY	13c. CITY OR TOWN ZIHLMAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN DELBROOK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CINDERELLA SATHOFF		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N.A. 213-22-4382		17. INFORMANT ADDRESS MRS. WANETTA BRANT, RAWLINGS, MD. 21557	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> 1539 DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>Intestinal obstruction</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 28</i> 19 <i>84</i> to <i>Feb 28</i> 19 <i>84</i> that (I) (we) last saw the deceased alive on <i>Feb 28</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Chang MD</i>		DEGREE M.D.		22c. DATE SIGNED 2/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OH, CHANG MD		22e. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/2/84	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD.
24. FUNERAL DIRECTOR NAME SOWERS FUNERAL HOME		60 W. MAIN ST. ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 06 1984	
		FROSTBURG		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-5210.

SOWERS FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRAR 60 W. MAIN ST. FROSTBURG, MD 21532				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
MADELINE ANNA DUDLEY				FEBRUARY 9, 1984			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		5/21/17		66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE		OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE ADDRESS)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		ALLEGANY		ZIEHLMAN		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
MARTIN		LOCKARD		MRS. LEANNAH DONALD, RT. 2 BOX 142, FROSTBURG, MD. 21532			
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
213223275		MRS. LEANNAH DONALD, RT. 2 BOX 142,		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Diabetes Mellitus; Stroke; Hypertension; possible cancer of colon							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
W. H. Hines, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
HIJAB, WALLY M.D.				909-A SETON DR. CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		2/12/84		ECKHART CEMETERY		ECKHART ALLEGANY MD. STATE	
24. FUNERAL DIRECTOR				25. REGISTRAR'S SIGNATURE			
NAME <u>Walter M. Hines</u> ADDRESS 60 W. MAIN ST. FROSTBURG				FEB 14 1984 <u>J. H. Davidson</u>			

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03082

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BEULAH CAROLINE DUFUR			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1, 1984			2b. HOUR 6:30A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 8 06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEacher	
						12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Dwight Eyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Lewis Isaacs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-6602		17. INFORMANT ADDRESS Mrs. Jeannette Leasure 1804 Bedford St. Cumberland, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

1719
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on Feb. 1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L.R. Miles M.D.		DEGREE M.D.				22c. DATE SIGNED 2-1-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ZAMAN, QAMAR M.D.		L.R. MILES, JR M.D.		22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/1/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR FEB 03 1984		25b. REGISTRAR'S SIGNATURE John E. Carver	

1356

DOWN

RECEIVED FEBRUARY 1 1907

LIBRARY

STREET 100 WEST

FEB 03 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

SCARPELLI FUNERAL HOME				STATE OF MARYLAND	
1- FOR STATE REGISTRAR 108 VA. AVE. CUMBERLAND, MD21502				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
LOTTIE JANE ELBON				FEBRUARY 1, 1984	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		White		July 30, 1898	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	
West Virginia		USA		85	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Cumberland		SACRED HEART HOSPITAL		ALLEGANY COUNTY, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	
Housewife		In Own Home		13a. STATE Maryland	
13b. COUNTY Allegany		13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE	
Adrian Floyd Moreland		Martha Simon		946 Weires Ave. 21502	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		232-26-9545		Mrs. Erma D. Deputy, La Vale, Md. Daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive and Coronary Art. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic lung disease; Diabetic Mellitus; Uremia; pulmonary emboli</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
HIJAB, WALLY S. M.D.				909-A SETON DR. CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-4-1984		Hillcrest Burial Park	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE RECEIVED BY REGISTRAR	
James F. Scarpelli, Cumberland, Md.				Feb 07 1984	

BP

1100 YAFELL

John R. ...

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03084

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ARLENE (ARLEY) GRACE EVANS				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 10, 1984		2b. HOUR 4:58 A. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Linene Folder		12b. KIND OF BUSINESS OR INDUSTRY Laundry	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST Jerome Swartley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Annie Virginia Rohrer 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-5515		17. INFORMANT ADDRESS Mr. Wayne E. Shook, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL ILLIOFEMORAL THROMBOSIS</u> <u>4538</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CONGESTIVE HEART FAILURE, HYPERKALEMIA, COPD</u>							
19a. DATE OF OPERATION <u>2/9/84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BIL. ILLIOFEM. THROMBOSIS</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> 19 <u>84</u> , to <u>2/10</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2/9</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>Dr. Schroeder</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/10/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Schroeder				22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-13-1984		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25. PREPARED BY FEB 13 1984 <u>John D. Rouse</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1953



Handwritten notes and text, mostly illegible due to fading and bleed-through. Some words like "Algebra" and "Geometry" are faintly visible.

Handwritten notes in the middle section, including what appears to be a date "1953" and some illegible text.

Handwritten notes at the bottom of the page, including a signature and some illegible text.

Handwritten notes at the very bottom, including a date "1953" and some illegible text.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03085

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eda Piscentini Fauss			2a. DATE OF DEATH MONTH DAY YEAR Feb. 8, 1984			2b. HOUR 6:16 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Calif.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired -Md.		12b. KIND OF BUSINESS OR INDUSTRY Dept. Social Services		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 913 Brentwood St. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Archie Piscentini				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Manganelli						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 550-18-7645		17. INFORMANT ADDRESS Mr. Ernest J. Fauss, Jr. Cumberland, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the Breast 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/11/78 to 12/13 19 81 , that (I) (we) last saw the deceased alive on 12/13 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard L. Snider				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. RICHARD L. SNIDER, M.D.				22e. ADDRESS Memorial Hospital Medical Building Cumberland, Md. 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-11-1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR FEB 15 1984 REGISTRAR'S SIGNATURE John Davidson Nordell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked either (a) or (b), a copy of this certificate must be retained at all times.)

1865

EDWARD

CHIEF

20%

Feb 1865

FEB 1865

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Belle O. Fullerton				2a. DATE OF DEATH MONTH DAY YEAR 02 04 84				2b. HOUR P M 5:45			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 16 86		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor N.H., Cumberland, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 618 Virginia Ave 21502					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland							
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Fullerton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Copeland									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-40-3281		17. INFORMANT ADDRESS Lions Manor N.H., Seton Dr., Cumb. MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <u>Sepsis</u> <u>Urinary tract infection</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>76</u> , to <u>02-04</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE <u>Ralph P. Erdly</u> MD				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-6-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph P. Erdly, M.D.				22e. ADDRESS 44 Scott Court, Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-7-1984		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli				ADDRESS Cumberland, Md. 21502				25. DATE REC'D. BY REGISTRAR FEB 9 1984			
				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>							

BP

5

27

11

677 *Journal of Interpersonal Violence* 26(4)

1999 1998 1997 1996 1995 1994 1993 1992 1991 1990 1989 1988 1987 1986 1985 1984 1983 1982 1981 1980 1979 1978 1977 1976 1975 1974 1973 1972 1971 1970 1969 1968 1967 1966 1965 1964 1963 1962 1961 1960 1959 1958 1957 1956 1955 1954 1953 1952 1951 1950 1949 1948 1947 1946 1945 1944 1943 1942 1941 1940 1939 1938 1937 1936 1935 1934 1933 1932 1931 1930 1929 1928 1927 1926 1925 1924 1923 1922 1921 1920 1919 1918 1917 1916 1915 1914 1913 1912 1911 1910 1909 1908 1907 1906 1905 1904 1903 1902 1901 1900 1899 1898 1897 1896 1895 1894 1893 1892 1891 1890 1889 1888 1887 1886 1885 1884 1883 1882 1881 1880 1879 1878 1877 1876 1875 1874 1873 1872 1871 1870 1869 1868 1867 1866 1865 1864 1863 1862 1861 1860 1859 1858 1857 1856 1855 1854 1853 1852 1851 1850 1849 1848 1847 1846 1845 1844 1843 1842 1841 1840 1839 1838 1837 1836 1835 1834 1833 1832 1831 1830 1829 1828 1827 1826 1825 1824 1823 1822 1821 1820 1819 1818 1817 1816 1815 1814 1813 1812 1811 1810 1809 1808 1807 1806 1805 1804 1803 1802 1801 1800 1799 1798 1797 1796 1795 1794 1793 1792 1791 1790 1789 1788 1787 1786 1785 1784 1783 1782 1781 1780 1779 1778 1777 1776 1775 1774 1773 1772 1771 1770 1769 1768 1767 1766 1765 1764 1763 1762 1761 1760 1759 1758 1757 1756 1755 1754 1753 1752 1751 1750 1749 1748 1747 1746 1745 1744 1743 1742 1741 1740 1739 1738 1737 1736 1735 1734 1733 1732 1731 1730 1729 1728 1727 1726 1725 1724 1723 1722 1721 1720 1719 1718 1717 1716 1715 1714 1713 1712 1711 1710 1709 1708 1707 1706 1705 1704 1703 1702 1701 1700 1699 1698 1697 1696 1695 1694 1693 1692 1691 1690 1689 1688 1687 1686 1685 1684 1683 1682 1681 1680 1679 1678 1677 1676 1675 1674 1673 1672 1671 1670 1669 1668 1667 1666 1665 1664 1663 1662 1661 1660 1659 1658 1657 1656 1655 1654 1653 1652 1651 1650 1649 1648 1647 1646 1645 1644 1643 1642 1641 1640 1639 1638 1637 1636 1635 1634 1633 1632 1631 1630 1629 1628 1627 1626 1625 1624 1623 1622 1621 1620 1619 1618 1617 1616 1615 1614 1613 1612 1611 1610 1609 1608 1607 1606 1605 1604 1603 1602 1601 1600 1599 1598 1597 1596 1595 1594 1593 1592 1591 1590 1589 1588 1587 1586 1585 1584 1583 1582 1581 1580 1579 1578 1577 1576 1575 1574 1573 1572 1571 1570 1569 1568 1567 1566 1565 1564 1563 1562 1561 1560 1559 1558 1557 1556 1555 1554 1553 1552 1551 1550 1549 1548 1547 1546 1545 1544 1543 1542 1541 1540 1539 1538 1537 1536 1535 1534 1533 1532 1531 1530 1529 1528 1527 1526 1525 1524 1523 1522 1521 1520 1519 1518 1517 1516 1515 1514 1513 1512 1511 1510 1509 1508 1507 1506 1505 1504 1503 1502 1501 1500 1499 1498 1497 1496 1495 1494 1493 1492 1491 1490 1489 1488 1487 1486 1485 1484 1483 1482 1481 1480 1479 1478 1477 1476 1475 1474 1473 1472 1471 1470 1469 1468 1467 1466 1465 1464 1463 1462 1461 1460 1459 1458 1457 1456 1455 1454 1453 1452 1451 1450 1449 1448 1447 1446 1445 1444 1443 1442 1441 1440 1439 1438 1437 1436 1435 1434 1433 1432 1431 1430 1429 1428 1427 1426 1425 1424 1423 1422 1421 1420 1419 1418 1417 1416 1415 1414 1413 1412 1411 1410 1409 1408 1407 1406 1405 1404 1403 1402 1401 1400 1399 1398 1397 1396 1395 1394 1393 1392 1391 1390 1389 1388 1387 1386 1385 1384 1383 1382 1381 1380 1379 1378 1377 1376 1375 1374 1373 1372 1371 1370 1369 1368 1367 1366 1365 1364 1363 1362 1361 1360 1359 1358 1357 1356 1355 1354 1353 1352 1351 1350 1349 1348 1347 1346 1345 1344 1343 1342 1341 1340 1339 1338 1337 1336 1335 1334 1333 1332 1331 1330 1329 1328 1327 1326 1325 1324 1323 1322 1321 1320 1319 1318 1317 1316 1315 1314 1313 1312 1311 1310 1309 1308 1307 1306 1305 1304 1303 1302 1301 1300 1299 1298 1297 1296 1295 1294 1293 1292 1291 1290 1289 1288 1287 1286 1285 1284 1283 1282 1281 1280 1279 1278 1277 1276 1275 1274 1273 1272 1271 1270 1269 1268 1267 1266 1265 1264 1263 1262 1261 1260 1259 1258 1257 1256 1255 1254 1253 1252 1251 1250 1249 1248 1247 1246 1245 1244 1243 1242 1241 1240 1239 1238 1237 1236 1235 1234 1233 1232 1231 1230 1229 1228 1227 1226 1225 1224 1223 1222 1221 1220 1219 1218 1217 1216 1215 1214 1213 1212 1211 1210 1209 1208 1207 1206 1205 1204 1203 1202 1201 1200 1199 1198 1197 1196 1195 1194 1193 1192 1191 1190 1189 1188 1187 1186 1185 1184 1183 1182 1181 1

Summary

10. *John Doe*

103-4-15

155

10 - 50

57

2-5-53

2025 © The McGraw-Hill Companies, Inc.

Handwritten: *Handwritten signature* 1890

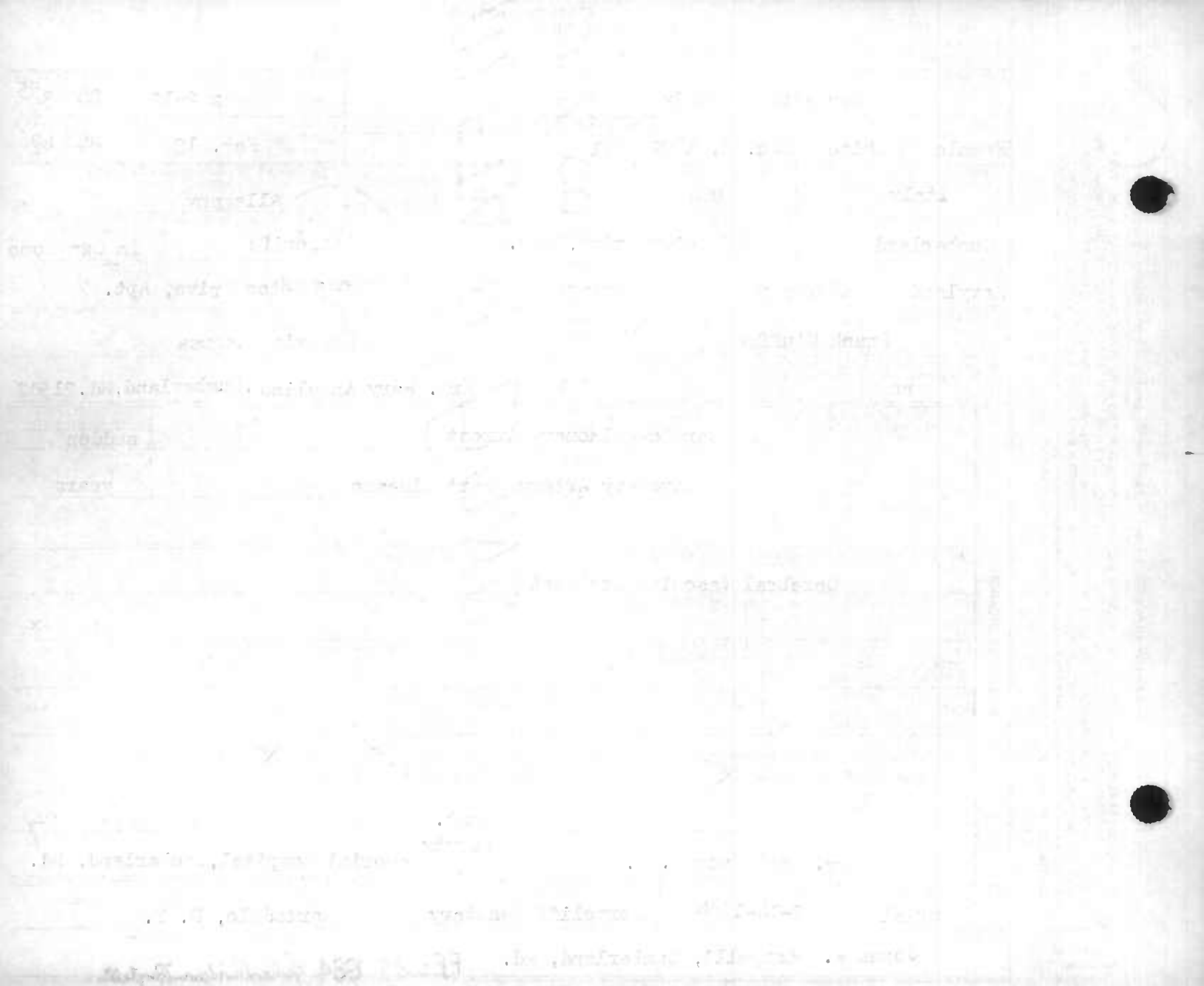
BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE INDICATE THE REASON THEREFOR IN ITEM 18. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR													
Concetta Giuffre										2-12 19 84										355 P.M.													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR																			
Female		White		Dec. 8, 1892		91 YRS.						Feb. 12 19 84		406 P.M.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH																					
Italy				USA				WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Allegany																					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																					
Cumberland				945 Seton Drive, Apt. 7				Housewife				In Own Home																					
13a. STATE										13b. COUNTY										13c. CITY OR TOWN													
Maryland										Allegany										Cumberland													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																							
Frank Giuffre										Rosaria Ragusa																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS																					
no								Mrs. Mary Angelino				Cumberland, Md. 21502																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1 DEATH WAS CAUSED BY:																																	
IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest																		sudden															
4140 } DUE TO, OR AS A CONSEQUENCE OF																																	
(b) Coronary Artery Heart Disease																		years															
DUE TO, OR AS A CONSEQUENCE OF																																	
(c)																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																	
Cerebral Vascular Accident																																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY?															
																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																									
				HOUR A.M. MONTH DAY YEAR																													
				P.M. 19																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION																									
								CITY OR TOWN COUNTY STATE																									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																	
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED													
Dr. Paul Snow M. D.										Asst. Deputy										2/12/84													
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										Memorial Hospital, Cumberland, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION																					
Burial				2-14-1984				Ferncliff Cemetery				Hartsdale, N. Y.																					
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE													
NAME James F. Scarpelli										ADDRESS																							
Cumberland, Md.										FEB 21 1984																							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elmer G. Hansel			2a. DATE OF DEATH MONTH DAY YEAR 02-17-1984			2b. HOUR 8:21 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 03 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF OVER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ballistics Wkr		12b. KIND OF BUSINESS OR INDUSTRY Supvr. Maintenance		
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt.#3, Box 160 21532	
14. FATHER'S NAME FIRST MIDDLE LAST David Hansel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Clark							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-05-9991		17. INFORMANT ADDRESS Lions Manor Nursing Hm., Seton Dr, Cumberland,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebrovascular accident 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Previous CVA.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Previous CVA.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from March 4 19 80 , to February 17 19 84 , that (I) (we) last saw the deceased alive on February 17 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Ralph Erdly M.D.						DEGREE M.D.		22c. DATE SIGNED 2-18-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Erdly, M.D.						22e. ADDRESS Seton Drive Lions Manor Nursing Home, Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 20 '84		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gdns. La Vale, Allegany, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md.										

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18, state any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) CLARENCE HERBERT HARPER					February 9, 1984					12:08 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Blacksmith		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 724 Elm St. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Lester C. Harper					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Evans						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-07-9627		17. ADDRESS Mrs. Ruth D. Harper, Cumberland, Md. Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 RESPIRATORY FAILURE. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulm. Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cor Pulmonale, Hypertension, Dehydration											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ranjithan				22e. ADDRESS Medical Building, Memorial Hosp. & Med. Center Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-12-1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR NAME James F. Scarpelli				ADDRESS Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03090

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LENA HOPKIN HORN			2a. DATE OF DEATH MONTH DAY YEAR February 18, 1984			2b. HOUR 7:57 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 4 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE WV			13b. COUNTY Hampshire		13c. CITY OR TOWN Springfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P. O. Box 15 26763	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Jackson Horn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virzila Ann Lewis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-72-9050		17. INFORMANT ADDRESS John E. Horn, P. O. Box 15, Springfield, WV 26763					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5308 PROBABLY ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) Dilatation of Proximal Esophagus DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	---	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Q. Zaman		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Q. Zaman		22e. ADDRESS Medical Bldg. Memorial Hospital & Med. Center Cumberland, MD 21502					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/84		23c. NAME OF CEMETERY OR CREMATORY Branch Mt. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Three Churches Hampshire WV	
24. FUNERAL DIRECTOR NAME Keith S. Shaffer Shaffer Funeral Home, Romney, WV 26757				25a. DATE REC'D. BY REGISTRAR FEB 24 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

1. The first of the two main points of the report is that the United States has a long and honorable tradition of supporting the people of the world in their struggle for freedom and independence. This tradition is based on the principles of the Declaration of Independence and the Constitution of the United States.

10/1/54

10/1/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) WALTER ALEXANDER HOWSER					2a. DATE OF DEATH MONTH DAY YEAR February 26, 1984			2b. HOUR 11 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Garman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1528 C. Oldtown Manor Apts. 21502		
14. FATHER'S NAME FIRST MIDDLE LAST Timothy L. Howser					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amie Shumate				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-05-4570		17. INFORMANT ADDRESS Mrs. Arvella Howser, Cumberland, Md. Wife					
18. CAUSE OF DEATH (Enter only one cause per line, in order of importance) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 } DUE TO, OR AS A RESULT OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) PA H cellulm									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>Feb. 26</u> 19 <u>84</u> to <u>Feb. 26</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>Feb. 26</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.									
22b. SIGNATURE <i>Terry Williams</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-27-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams		22e. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-29-84		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR MAR 0 2 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

80
3

1

APR 1, 1971

WHITE

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03092

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William R. Hutson			2a. DATE OF DEATH MONTH DAY YEAR Feb. 2, 1984			2b. HOUR 7:50A M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 4, Mexico Farms				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer			12b. KIND OF BUSINESS OR INDUSTRY Local #6		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 305 Reynolds St. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Oswald J. Hutson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Pearl Adams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-24-7463		17. INFORMANT ADDRESS Mrs. Dolly Hutson, Cumberland, Md. Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>CA of Lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH w/eff	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. R. Espina, M. D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-3-1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. R. Espina, M. D.						22e. ADDRESS 907 Seton Drive, Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-5-1984		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502						25a. DATE REC'D. BY REGISTRAR FEB 07 1984			25b. REGISTRAR'S SIGNATURE John J. Carney		

35
20
35
11
1

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1346

W 211

CA of New

W 211

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR GROVE FUNERAL HOME 1- STATE HANCOCK, MD. REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE IRVINE GREEN JOY				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 4, 1984				2b. HOUR 9:05 P _M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCT 19 1909 FEB 17 1984		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Garment			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Little Orleans		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 111 21766	
14. FATHER'S NAME FIRST MIDDLE LAST John Norris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie B. Jerome							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 28 9345		17. INFORMANT Elmer A. Joy				ADDRESS same as 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary-Cardio Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pulmonary Neoplasm with DUE TO, OR AS A CONSEQUENCE OF (c) Metastases to Bone, cervical spine, acetabulum PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN 29 19 84 to FEB 4 19 84, that (I) (we) last saw the deceased alive on 2/4/ 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard Schindler M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SCHINDLER, M.D.						22e. ADDRESS 69 GREENE STREET CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/8/84		23c. NAME OF CEMETERY OR CREMATORY Piney Plains Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Little Orleans Allegany Md.			
24. FUNERAL DIRECTOR Richard Grove						25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

RECEIVED

RECEIVED

CAVE REPAIR WORK
HUNTER, MD.

10-10

11-10

12-10

FEBRUARY 11, 1962

0-102 B

ALLIANCE COUNTY

CAVE REPAIR WORK

EDWARD S. HUNTER, M.D.
60 GREEN STREET CLEVELAND, OH. 43102

RECEIVED FEB 14 1962

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1- STATE REGISTRAR 309 DECATOR ST. CUMBERLAND, MD.				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) GEORGE ROBERT KELLER				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 10, 1984		2b. HOUR P.M. 8:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 25, 1957		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 26	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Instructor		12b. KIND OF BUSINESS OR INDUSTRY Chemical	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George R. Keller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary O'Rourke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216743385		17. INFORMANT ADDRESS Mary Keller, Cumberland, Md. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene V. Mazzocco				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE V. MAZZOCCO, M.D.				22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 13, 84		23c. NAME OF CEMETERY OR CREMATORY St. Patrick Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME William G. Kight, Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR FEB 15 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as above.

NOT RECORDED

RECORDS SECTION

DATE: FEBRUARY 10, 1950

NAME: MARY KELLER

RESIDENCE: ALLEGANY COUNTY

EMPLOYER: CHEMICAL

ALLEGANY ALLEGANY CUMBERLAND

GEORGE J. KELLER

NO. 21505

MARY KELLER, CUMBERLAND, MD. 21505

GEORGE J. KELLER, M.D. 21505

FOR: 13, 64 41. Patrick Conn. Cumberland, Allegany, Md.

WILLIAM E. KELLER, CUMBERLAND, MD. 21505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Anna M Kidwell					2/21/84	
3. SEX		4. RACE		5. DATE OF BIRTH		2b. HOUR
Female		White		MONTH DAY YEAR 04 09 05		5:30p M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS
Maryland		America		78 YRS.		IF UNDER 24 HRS HOURS MIN.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH		
Frostburg		Frostburg Community Hospital		Alleg. MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Housewife						
13a. STREET ADDRESS		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
222 Green St		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21562		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
James Casserly		Mary Ellen Madden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		235 16 5822		220 Greene St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF				
4292		Respiratory failure				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) COPD with exacerbation, CHF				
		(c) DVT, embolism				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not see the body after death.		19 84 to Feb 21 19 84		that (I) (we) lost and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
Dr. S. Kim		MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		2/23/84		St. Peter's Cemetery		Westernport Allegany Md
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		
Wm. A. Fredlocks		31 Jones St. Piedmont, WV		FEB 27 1984		
Fredlocks				25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

BP

11

11

11

11

11

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) SYLVIA L LEE			2a DATE OF DEATH MONTH DAY YEAR 02 19 84			2b HOUR 5:08 A.M.			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 03 11 25		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10 CITY OR TOWN OF DEATH CUMBERLAND MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a STATE MD		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 30 Roberts St. 21502	
14 FATHER'S NAME FIRST MIDDLE LAST Esra Wimer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Flora Appold					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO. 215-14-6597		17 INFORMANT ADDRESS Mr. Michael L. Lee, City Son			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD - Acute m.i. 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE MD						DEGREE MD		22c. DATE SIGNED 2-20-1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS Memorial Hospital, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-22-1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, Md 21502									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicare committee must be notified at once.

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

10 10 30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified and charged.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie S. Lewis			2a. DATE OF DEATH MONTH DAY YEAR 2/25/84			2b. HOUR 11:30a			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/ 23/ 94		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER		12b. KIND OF BUSINESS OR INDUSTRY CEMENT PROD.	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 177 Mt Pleasant ST	
14. FATHER'S NAME FIRST MIDDLE LAST ELIJAH SMITH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE REED					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N.A.		17. INFORMANT FROSTBURG, MD. 21532 MR. HARPER LEWIS, 9 E. MECHANIC ST.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. A.S.C.V.D. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUODENAL ULCER (HEALED) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). RHEUMATOID - ARTHRITIS									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 2-24-84 to 2-25-84, that (I) (we) lost saw the deceased alive on 2-25-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.R. Diehl, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-26-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Diehl				22e. ADDRESS Frostburg, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/28/84		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK FROSTBURG ALLEGANY MD.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR Sowers Funeral				25a. DATE REC'D. BY REGISTRAR MAR 05 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03098	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) CHARLES E. LEWIS					2a. DATE OF DEATH FEBRUARY 3, 1984			2b. HOUR 7:30 PM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 6 18 1967		6. AGE (IN YEARS LAST BIRTHDAY) 17 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trackman		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. STATE Maryland				13b. COUNTY Garrett		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 2 Spring Lick Rd. 21561	
14. FATHER'S NAME Asa Lewis				15. MOTHER'S MAIDEN NAME Cora Ann Ludwig							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-05-9376		17. INFORMANT ADDRESS Mrs. Marian Lewis Rt. 2 Swanton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain stem stroke</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a. DATE OF OPERATION no operation				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Augusto Figueroa</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. AUGUSTO FIGUEROA				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/6/84		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser, Mineral West Virginia			
24. FUNERAL DIRECTOR NAME <u>Boal Funeral Service</u>				ADDRESS <u>Westernport, Md. 21562</u>				FEB 09 1984			

BP _____

of ex

7

31

... ..

5

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

on

... ..

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys M Lohr				2a. DATE OF DEATH MONTH DAY YEAR 2/28/84			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12/ 28/ 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co MD.	
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 56 Green St		13f. STREET ADDRESS 21532		14. FATHER'S NAME FIRST MIDDLE LAST Grover Cagey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lenora Moss	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215 44 9046		17. INFORMANT ADDRESS Jon Dale Lohr, Frostburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5700 IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of the liver DUE TO, OR AS A CONSEQUENCE OF (c) Post-hepatitis necrosis in childhood APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Arteriosclerotic heart disease - Congestive failure - Anemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-3 1975 to 2/28 1984 that (I) (we) last saw the deceased alive on 2/27 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. S.L. Sandhir		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S.L. Sandhir		22e. ADDRESS 48 Tarn Terrace, Frostburg					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 1, 1984		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		ADDRESS Mar 06 1984		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP



1911

Own Home

Home

Home

Home

Home

Home

For Sale Home, Frederick, Md.

No

X

Mar. 1, 1908 Frederick, Md. in Frederick, Md.

Mar. 1, 1908

Mar. 1, 1908 Frederick, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

031000

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RITA U. LYONS			2a. DATE OF DEATH MONTH DAY YEAR February 1, 1984			2b. HOUR 3:50 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 25, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Knitting Co.		
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 715 Hilltop Drive 21502		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph O. Mellott				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Ann Clay							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-14-5112		17. INFORMANT ADDRESS Mr. Edward T. Lyons, Cumberland, Husband						
18. CAUSE OF DEATH (Enter only one cause per line, in order of sequence) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>myocardial infarction</i> (c) <i>probably coronary CA = myocardial infarction</i> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Small Bowel Obstruction</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 31</i> 19 <i>84</i> to <i>Feb 1</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Jan 31</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)											
22b. SIGNATURE <i>Dr. Terry Williams</i>			DEGREE <i>ms</i>			22c. DATE SIGNED <i>2-2-84</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams			22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502								
23a. BURIAL, CREMATION, REMOVAL 15P Burial			23b. DATE 2-4-1984		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli ADDRESS Cumberland, Md. 21502											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FEB 07 1984 John J. Cawley

100



[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

MEDICAL CERTIFICATION

SOWESS FUNERAL HOME 60 WEST MAIN STREET FROSTBURG, MD. 21532				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. FOR STATE REGISTRAR				REG. NO. 03101			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GOLDIE FAYE MACMILLAN				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 17, 1984		2b. HOUR 22:45 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2/18/06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE IN SUCH INSTITUTION)				13a. STATE MARYLAND			
13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 223 W. MAIN STREET, APT. 6 21532	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS CALIHAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINNIE STAGE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N.A.			
16b. SOCIAL SECURITY NO. 215-18-8518		17. INFORMANT AD. FROSTBURG, MD. 21532 MR. JAMES L. MACMILLAN, 223 W. MAIN ST.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 1579 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction = CAD</i> (c) <i>Adenocarcinoma of pancreas</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Diabetes mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 14 1984</i> to <i>Feb 17 1984</i> , that (I) (we) last saw the deceased alive on <i>Feb 17 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Chang Oh Chang M.D.</i>				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. OH CHANG, M.D.				22e. ADDRESS 48 TARN TERRACE, FROSTBURG, MD. 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/20/84		23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BARTON ALLEGANY MD.	
24. FUNERAL HOME OR ADDRESS SOWESS FUNERAL HOME 60 W. MAIN ST. FROSTBURG				25a. DATE REC'D. BY REGISTRAR FEB 24 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

300 WEST MAIN STREET
 PROSTERSBURG, MD. 21550

LOUIS	CALIFORNIA	LIMITS	STARS	MARYLAND ALLSBY	PROSTERSBURG	323 W. MAIN STREET, APT. B	HOUSING	ALLSBY COUNTY	77	FEBRUARY 17, 1958
NO	U.S.A.	215-18-215	MR. JAMES L. WACHMAN, 323 W. MAIN ST.,	PROSTERSBURG, MD. 21550						
CHURCHLAND	SACRED HEART HOSPITAL									
U.S.A.										
WIFE	215-18-215									
WIFE	215-18-215									

300 WEST MAIN STREET
 PROSTERSBURG, MD. 21550

215-18-215
 MR. JAMES L. WACHMAN, 323 W. MAIN ST.,
 PROSTERSBURG, MD. 21550

300 WEST MAIN STREET
 PROSTERSBURG, MD. 21550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Francis J. Martz				2a. DATE OF DEATH MONTH 02 DAY 02 YEAR 84				2b. HOUR 6:30 ^A _M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 09 DAY 01 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 24 HRS. HOURS 00 MIN. 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor, Seton Dr., Cumb., MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brewery Worker		12b. KIND OF BUSINESS OR INDUSTRY Brewing			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 540 Henry Drive 24502			
14. FATHER'S NAME FIRST Henry MIDDLE Martz LAST Martz				15. MOTHER'S MAIDEN NAME FIRST Anne MIDDLE Metzner LAST Metzner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown NO				16b. SOCIAL SECURITY NO. 214-05-4765		17. INFORMANT ADDRESS Lions Manor N.H., Seton Dr., Cumb., MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral anoxia DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Advanced Parkinson's Disease - Hypertension											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 01-05 , 19 84 , to 02-02 , 19 84 , that (I) (we) last saw the deceased alive on 01-31 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ralph P. Erdly, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-2-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph P. Erdly, M.D.				22e. ADDRESS 44 Scott Court, Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/4/84		23c. NAME OF CEMETERY OR CREMATORY Fbg. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, MD			
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.				ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR FEB 6 1984		25b. REGISTRAR'S SIGNATURE John J. Hafer			

BP

05:00 10 50 50

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03103

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST (Margaret) MARGARET VIOLA MCCARTY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 2, 1984			2b. TIME OF DEATH 4:20 A. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1900		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY In Own Home							
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Willowbrook Road 21502							
14. FATHER'S NAME FIRST MIDDLE LAST Daniel E. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Avery			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-74-2353		17. INFORMANT ADDRESS Mrs. Ruth Frederick, Cumberland, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4809 DUE TO, OR AS A CONSEQUENCE OF (b) Viral Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic lung disease (bronchitis)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 6 weeks > 10 yrs
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 29, 1983 , to 2-2, 1984 , that (II) (we) last saw the deceased alive on 2-1-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, it did not) view the body after death.							
22b. SIGNATURE William D. Lamm MD				DEGREE MD		22c. DATE SIGNED 2/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM D. LAMM				22e. MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			

23a. BURIAL, CREMATION, REMOVAL (SP) Burial		23b. DATE 2-4-1984		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE La Vale Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25. DATE OF REGISTRATION FEB 7 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



11/19/11
FEB 07 1984
Faint handwritten text at the bottom left.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified, and the death certificate must be signed by the medical examiner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) THELMA LEONA MCILWEE			2a. DATE OF DEATH MONTH DAY YEAR February 23, 1984		2b. HOUR 10:35 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 09 99		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Jacob J. Glotfelty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Naomi Miller		13e. STREET ADDRESS / ZIP CODE 12608 Bowling St. SW 21502		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-05-5612		17. INFORMANT ADDRESS Wm. Shearer - 945 Seton Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 25 DAYS 4100 DUE TO, OR AS A CONSEQUENCE OF (b) WITH LEFT VENTRICULAR FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) C.I.D. YEARS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 2/23/84 to 2/23/84, that (2) (we) lost view the deceased on 2/23/84, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death)						
22b. SIGNATURE Dr. S. Nathan		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/23/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Nathan		ADDRESS 1201 DR. NATHAN		Medical Building, Memorial Hosp. & Med. Cntr. Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/26/84		23c. NAME OF CEMETERY OR CREMATORY Grantsville Ceme.		23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, MD
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR FEB 27 1984		25b. REGISTRAR'S SIGNATURE [Signature]

BP

John T. Hater, Jr., Raleigh, NC
 2/23/84
 2/23/84

2910
 2/23/84

Jacob
 (Mirrored)
 Room
 2/23/84

Newland
 2/23/84

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			03105		
1. DECEASED NAME (TYPE OR PRINT) BRADY David MONGOLD, Sr.			2a. DATE OF DEATH MONTH DAY YEAR February 13, 1984		2b. HOUR 6:39 A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 2 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WVa		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Alleghany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
13a. STATE Maryland		13b. COUNTY Alleghany		13c. STREET ADDRESS / ZIP CODE 703 Elm Street 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Guy David Mongold			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Margabet Iman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 234-40-3683		17. INFORMANT ADDRESS Mayselle Cosner 703 Elm St Cumberland,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Pk Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: COPD old Polymyolitis					
19a. DATE OF OPERATION Burial		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED old Polymyolitis		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Moti L. Koul			22c. DATE SIGNED		22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Moti L. Koul			22f. ADDRESS 925 Bishop Walsh Dr., Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/15/84		23c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Lahmansville Grant W		24. FUNERAL DIRECTOR Blaine Schaffner 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR SIGNATURE Feb 17			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.



100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

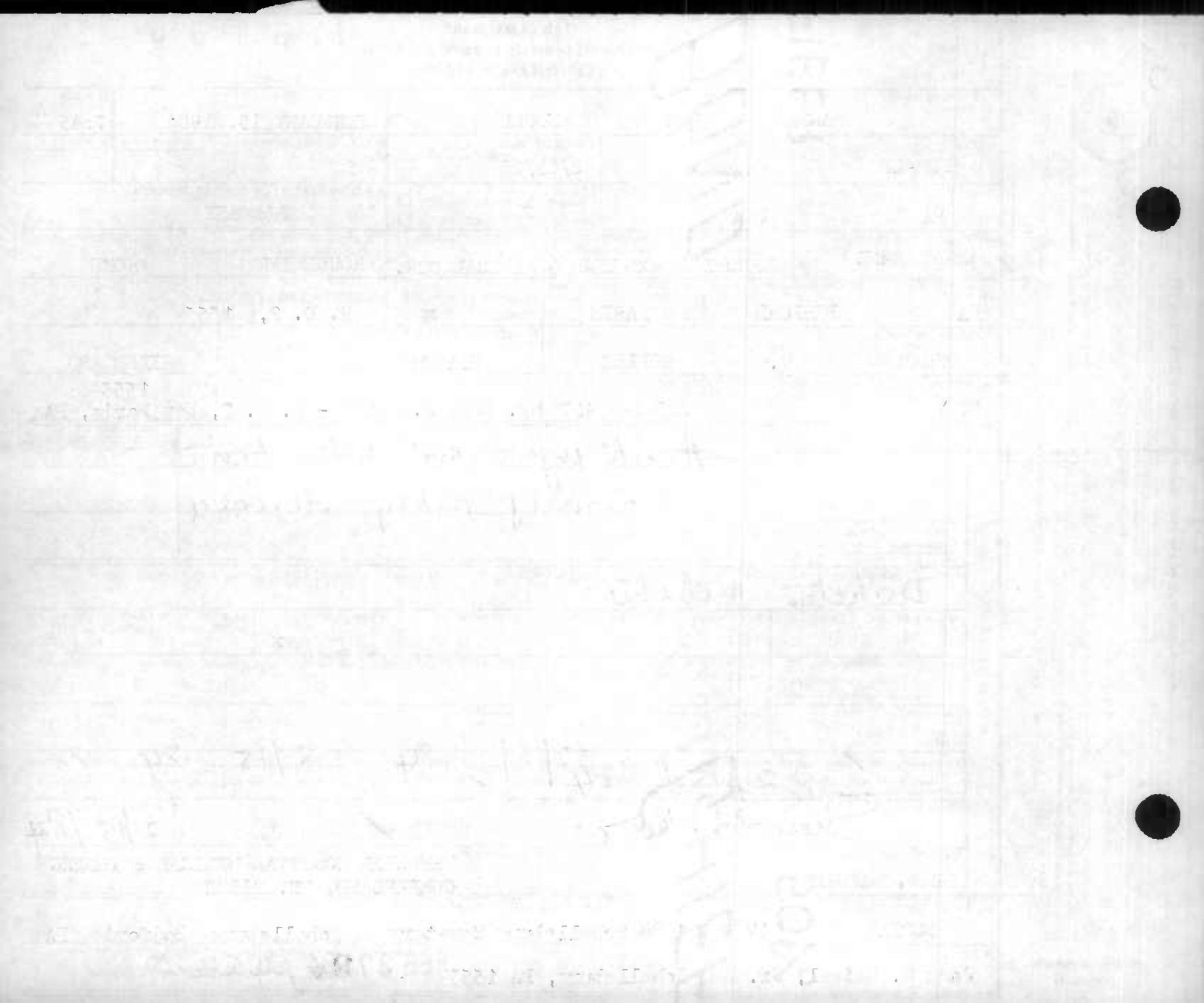
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03106

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA LEE MOORE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1984			2b. HOUR 7:45 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2/23/25		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CTR.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE PA		13b. COUNTY BEDFORD		13c. CITY OR TOWN NEW PARIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE R. D. 2, 15554	
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR W. HOLLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BLANCHE HILLEGASS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-16-6437		17. INFORMANT ADDRESS 15554 MR. ROSS S. MOORE - R. D. 2, New Paris, PA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I (this hospital) attended the deceased from <u>2/8/84</u> to <u>2/15/84</u> , that (we) last saw the deceased alive on <u>2/15/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. S. Nathan</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/15/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR S. NATHAN					22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 17 FEB 1984		23c. NAME OF CEMETERY OR CREMATORY Schellsburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Schellsburg Bedford PA		
24. FUNERAL DIRECTOR NAME Jack H. Geisel, Jr.					ADDRESS Schellsburg, PA 15554		25. DATE RECEIVED BY REGISTRAR FEB 27 1984		
25a. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					25b. REGISTRAR'S SIGNATURE				



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRANVILLE F MORELAND			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1984			2b. HOUR MIN. 12:08 AM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 - 20-1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE West Virginia		13b. COUNTY Hampshire		13c. CITY OR TOWN Capon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE General Delivery 26744	
14. FATHER'S NAME FIRST MIDDLE LAST Mariam Bridge Moreland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Hiett Moreland		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 234-46-6736		17. INFORMANT ADDRESS Herman A. Snoots, Springfield, WV							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) central vascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/22/84 to 2/23/84 , that (I) (we) last saw the deceased alive on 2/22/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Thaddeus Elder		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thaddeus Elder		19. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-25-1984		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gore, Frederick, VA			
24. FUNERAL DIRECTOR NAME Giffin Funeral Home		ADDRESS Home, Capon Bridge, WV		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE John Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please return carbon-papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

RECEIVED
FEB 20 1968

State	Miss	4 - 30-1908	to
West Virginia	USA		Alaska
			Bus Driver
			General Delivery 20711
			Portland
			West
			Alaska
			Barrow, Alaska, Barrow Field, WY

x

WEST VIRGINIA
FEB 20 1968
Barrow, Alaska, Barrow Field, WY
General Delivery 20711
Portland
West
Alaska

SCARPELLI FUNERAL HOME

STATE OF MARYLAND

03108

1. FOR VIRGINIA AVE.,
STATE REGISTRAR CUMBERLAND, MD 21502DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BETTY LOUISE NATALE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 8, 1984			2b. HOUR 6:35 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		12b. KIND OF BUSINESS OR INDUSTRY Physician	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 902 Harding Ave. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Walter H. Baker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Caton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 184-20-6678		17. INFORMANT ADDRESS Mr. Herbert J. Natale, Cumberland, Husband			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 min

4/48

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Cardiac Arrhythmia

10 min

DUE TO, OR AS A CONSEQUENCE OF

(c)

Coronary disease Pres M1

year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Diabetes mellitus - ~~Diabetes mellitus~~

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING ☒ MEDICAL ☐ STAFF
PHYSICIAN DIRECTOR PHYSICIAN

2-10-84

V. EUGENE MAZZOCCO

BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial23b. DATE
2-11-198423c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park23d. LOCATION
CITY OR TOWN COUNTY STATE
Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR

NAME James F. Scarpelli, ADDRESS
Cumberland, Md. 21502

FEB 15 1984 BY REGISTRAR 25. REGISTRAR'S SIGNATURE

Julia Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

ROBERT L. FURMAN, JR.
VIRGINIA AVE.
COLUMBIA, MD. 21002

PETTY L. RISE NATALIE L. RISE

ALLEGANY COUNTY

SACRED HEART HOSPITAL

100-20-6000

ENC. 212 SECOND DRIVE, COLUMBIA, MD. 21002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR						7a. DATE OF DEATH MONTH DAY YEAR						7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE E. NICEWARNER						FEBRUARY 26, 1984						11:20 ^a M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 24 13		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 70		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.							
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 212 Grand Ave. - 21502					
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Robey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Conrad							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-07-5411		17. INFORMANT ADDRESS Mrs. Mabel Lafferty, Lake Gordon Rd. Sister									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR TACHYCARDIA</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAD-</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO, OR AS A CONSEQUENCE OF (c) <u>25 MIN</u> <u>YEARS</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CA OF COLON - S/P RESECTION - 2 DAYS</u>													
19a. DATE OF OPERATION <u>2/24/84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA OF COLON</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
21g. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> 19 <u>84</u> to <u>2/26</u> 19 <u>84</u> that (I) (we) last saw the deceased on <u>2/26</u> 19 <u>84</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.													
21h. SIGNATURE <u>James F. Scarpelli</u>		DEGREE MD		21i. ATTENDING PHYSICIAN MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				21j. DATE SIGNED <u>2/28/84</u>					
21k. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver						22a. ADDRESS Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2-29-1984		23c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Terra Alta, W. Va.					
24. FUNERAL DIRECTOR NAME James F. Scarpelli						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 0 2 1984 Julia Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Particulars may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

SOWERS FUNERAL HOME				STATE OF MARYLAND			
1- FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
60 W MAIN STREET FROSTBURG, MD. 21532				CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
(TYPE OR PRINT)				MONTH DAY YEAR			
ESKEY NMI NINER				FEBRUARY 27, 1984			
3. SEX		4. RACE		5. DATE OF BIRTH		2b. HOUR	
FEMALE		WHITE		5/12/01		5:05A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR	
MARYLAND		U.S.A.		82 YRS		MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		ALLEGANY COUNTY MD.		OWN HOME	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
HOUSEWIFE				OWN HOME			
13a. STATE				13b. COUNTY			
MARYLAND				ALLEGANY			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
FROSTBURG				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
WILLIAM MILLER				JANIE LEWIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
NO				N.A. 212-74-9542			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			
MISS VIOLA NINER, 141 BOWERY ST., FROSTBURG, MD. 21532				<p>IMMEDIATE CAUSE (a) <i>Confused Heart Failure</i></p> <p>1749 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible Myocardial Infarct</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of Heart - Metastatic - Liver + Lungs</i></p>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK							
21f. LOCATION				21g. LOCATION			
STREET				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
<i>Raul V. Felipa</i>				2/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
DR. RAUL V. FELIPA, M.D.				925 BISHOP WALSH RD., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE			
BURIAL				3/1/84			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
ECKHART CEMETERY				CITY OR TOWN COUNTY STATE			
FROSTBURG				ALLEGANY MD.			
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
MAR 05 1984				<i>Julia Davidson-Randall</i>			

10:02A

FEBRUARY 27, 1980

MINER

WPI

ESLEY

PS

7/12/01

WEST

SPRING

ALLEGANY COUNTY

X

U.S.A.

CLARK

OWN HOME

BERNARD

SACRED HEART HOSPITAL

CLARK

21222

MR. A. H. HARRIS JR.

X

ALLIANCE PROTECTORS

CLARK

UNIT

UNIT

UNIT

UNIT

PROTESTANT, EL. 21222

U.S.A. 212-74-2222 212-74-2222 212-74-2222

U.S.A.

212-74-2222 212-74-2222 212-74-2222

212-74-2222 212-74-2222 212-74-2222

212-74-2222 212-74-2222 212-74-2222

212-74-2222 212-74-2222 212-74-2222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Bertha Louise Park				2a. DATE OF DEATH		2b. HOUR	
				MONTH DAY YEAR		12 20 84	
3. SEX Female		4. RACE white		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
				MONTH DAY YEAR		92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD/USA		USA				Allegany County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF BUSINESS OR MOST OF WORKING LIFE)	
Frostburg		Frostburg Village Nursing Home				housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Allegany		Lonaconing		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Frederick		Maria		NO			
17. INFORMANT		18. SOCIAL SECURITY NO.		19. ADDRESS			
Lee Stevens		212-32-8166		108 Neptune Drive Newark, Delaware			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular disease 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes mellitus; hypertension.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 25 19 78 , to Feb 20 19 84 , that (I) (we) last saw the deceased alive on Feb 7 19 84 , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Thomas J. Devlin M.D.		22c. DATE SIGNED 2-20-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL			
Thomas J. Devlin M.D.		55 Jackson Street, Lonaconing, Md. 21539		Cremation			
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE		23e. REGISTRAR'S SIGNATURE	
Feb. 21, 1984		24a. Smithsburg Crematory		Smithsburg Washington			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE	
George A. Eubank		8 E. Main St. Lonaconing, Md.		FEB 24 1984			

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03112

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST NELLIE FRANCES PATTISON			MONTH DAY YEAR FEBRUARY 23, 1984			11:01pM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. BALTIMORE CITY OR COUNTY OF DEATH		
FEMALE	White	San 15 1898	86			ALLEGANY MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
MD	USA		ALLEGANY			CUMBERLAND		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		
MEMORIAL HOSPITAL		Domestic		Housewife		13b. COUNTY		
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. ZIP CODE		
Cumberland				24 North Waverly Terrace		21602		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		
Charles Shoemaker			Mary Catherine Unknown			16b. SOCIAL SECURITY NO. 215-36-9626		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH		
Eleanor Clupp-Cumberland Md						Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>5860</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>RENAL FAILURE</u>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>74</u> , to <u>2-23</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-23-84</u> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>John Whitmore</u> DEGREE			22c. DATE SIGNED <u>2-24-84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN WHITMORE			22e. ADDRESS 1068 National Highway LAVALLE, MD 21502			22f. DATE RECD. BY REGISTRAR		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Cremation			2-25-84			Davis Funeral Home		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE RECD. BY REGISTRAR		
Boal Funeral Service Westernport						25b. REGISTRAR'S SIGNATURE MAR 0 2 1984		

MEDICAL CERTIFICATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible handwriting on lined paper. Some words like "The", "and", "of", "the" are visible.]

[Faint handwriting at the bottom of the page, possibly a signature or date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST GEORGE Michael RAINES					MONTH DAY YEAR FEBRUARY 25, 1984			P 11:06 M		
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR MONTHS DAYS		
Male		White		MONTH DAY YEAR 02 19 27		57 YRS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				ALLEGANY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL				farmer		dairy		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE					13c. COUNTY		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland					Allegany		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 38, Route #10/ 21502	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Charles Edward Raines					Cena Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					216 30 1775		Mary E. Raines - same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>yes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>CITF, Cardiomyopathy, DM, HBP</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William</u>					DEGREE <u>MD</u>			22c. DATE SIGNED <u>27 Feb 84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY J. BOLLINO, JR.					22e. ADDRESS 955 FREDERICK STREET CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			2/28/84		Pleasant Grove		Cumberland, Alleg., MD			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)					
John J. Hafer, Jr. LaVale, MD					FEB 29 1984 <u>John Davidson</u>					

BP

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

11:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

GEORGE-UPCHURCH				STATE OF MARYLAND				
1- FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				
202 GREENE ST CUMBERLAND, MD 21502				CERTIFICATE OF DEATH				
REG. NO.				03114				
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR
FIRST MIDDLE LAST ROSE LEE RHOADS				MONTH DAY YEAR 02/02/84				0400 am
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		
Female		White		MONTH DAY YEAR March 31, 1905		78 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.				ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		SACRED HEART HOSPITAL		Homemaker		Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Allegany Cumberland				YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME (FIRST MIDDLE LAST) Joseph - Smith				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) - Hall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -				16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS 041-58-5120 David Rhoads-13 Wall St., Norwalk, Conn.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Carcinoma of breast - widely met								
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/26, 1978, to 2/2, 1984, that (I) (we) lost saw the deceased alive on 2/1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		22c. DATE SIGNED		
Victor E. Mazzocco				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
XXXXXXXXXXXX Victor E. Mazzocco				922 SETON DRIVE CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		2/8/84		Beverdale Meml. Park		New Haven-New Haven Co.-Conn.		
24. FUNERAL DIRECTOR NAME				25a. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502				FEB 10 1984		John J. Grier		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03115			
1. DECEASED NAME (TYPE OR PRINT) GERALD CHARLES RILEY, JR.						2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 8, 1984				2b. HOUR 11:00 A. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 7, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 433 Homer Street 21502	
14. FATHER'S NAME Gerald C. Riley, Sr.						15. MOTHER'S MAIDEN NAME Viola Caroline Allen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Korean 723-14-7779		17. INFORMANT ADDRESS Anna M. Riley Cumberland, MD					
18. CAUSE OF DEATH (Enter only one cause per line. Do not use "I" or "D" for immediate cause.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy, Arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Myocardial infarction MI & Central neuritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CAD, CHF</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Feb. 7 8 AM, 30 84 to Feb. 8 19 84					
22. I certify that (I) (this hospital) (provided) the deceased from above, (I) (we) (did not) view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22a. SIGNATURE <i>Terry Williams</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22b. DATE SIGNED 2-9-84			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS				22d. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-10-84		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli				ADDRESS Cumberland MD 21502		25. DATE REC'D. BY REGISTRAR FEB 15 1984		26. REGISTRAR'S SIGNATURE <i>John Davidson-Rodden</i>			



Handwritten text, possibly a signature or date, appearing upside down.

Handwritten text, possibly a signature or date, appearing upside down.

Handwritten text at the bottom of the page, appearing upside down.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Myrtle Virginia Ritenour						2-13			19 84			12a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Female	White	May 26, 1888	97 YRS.			Feb. 13			19 84			12a.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia			USA						Allegany MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland			236 Elder St.			Retired Operator			Beauty Salon					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			236 Elder St. 21502		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST						FIRST MIDDLE LAST								
Jesse Womax						Mary Marple								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES: NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS		
No			220-10-9427			Mrs. Madeline Robinette Mrs. Georgia Robertson, Daughters								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(b) <u>Carcinoma of Colon</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
<u>Paul Snow</u>				Asst. Deputy				2/13/84						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
Dr. Paul Snow M. D.				Memorial Hospital, Cumberland, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				
Entombed				2-15-84		Rose Hill Mausoleum				Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
James F. Scarpelli				FEB 21 1984				<u>Julia Davidson</u>						

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLAUDE EDWARD ROHRBAUGH			2a. DATE OF DEATH MONTH DAY YEAR February 29, 1984			2b. HOUR 9:30 A.M.					
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carman		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. STATE WV			13b. COUNTY Mineral		13c. CITY OR TOWN Wiley Ford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Wiley Ford, WV 26767 99999		
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert A. Rohrbaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST A. M. Cole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705 10 7296		17. INFORMANT ADDRESS Ethel M. Rohrbaugh Wiley Ford, WV						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute MI.</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/29</u> 19 <u>84</u> to <u>4/29</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>P. Halmos</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/29/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Anthony Bollino</u>		22e. ADDRESS <u>955 Frederick Street</u> <u>Cumberland, MD 21502</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3-3-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Ft. Ashby Mineral WV</u>	
24. FUNERAL DIRECTOR <u>SCARPELLI FUNERAL HOME CUMBERLAND, MD</u>				DATE REC'D. BY REGISTRAR <u>MAR 8 1984</u>		REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES ALVIN SARVER			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 13, 1984		2b. HOUR 7:32 P M							
3. SEX MALE		4. RACE Caus.		5. DATE OF BIRTH MONTH DAY YEAR 6 16 06		6. AGE (IN YEARS EAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.						
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Ellerslie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21529/ Box 85 21529			
14. FATHER'S NAME FIRST MIDDLE LAST Ross M. Sarver				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ivana Miller								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 217-05-2201		17. INFORMANT ADDRESS Jennie Sarver, Box 85, Ellerslie, Md. 21529							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Congestive Cardiac failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. Moti Koul				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Moti Koul				22e. ADDRESS 925 Bishop Walsh Drive Cumberland, Maryland 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/16/84		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Lavale, Allegany, Md.				
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler, Hymenman, Pa. 15545						25a. DATE REC'D. BY REGISTRAR FEB 21 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03119					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY LILLIAN SCHELL								2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16, 1984				2b. HOUR 5:10 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? u.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Md.				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14 Pennsylvania Ave. Cumberland, 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Alonzo Wallace				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Meyers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-66-1103		17. INFORMANT ADDRESS Joseph H. Schell, 14 Penn. Ave. Cumberland, MD 21502							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCD = Recurrent CHF</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> , 19 <u>84</u> , to <u>2/16</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>W.C. Spiggle</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/18/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. C. Spiggle				22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21532									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/19/84		23c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lahmansville Grant WV					
24. FUNERAL DIRECTOR NAME Keith S. Shaffer ADDRESS Shaffer Funeral Home, Romney, WV						25a. DATE REC'D. BY REGISTRAR FEB. 27 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

SHOOTER RUFUS WINE
370 E. MAIN STREET
TOMMY JAW

FEBRUARY 12, 1934

SCHILL

LILLIAN

MAY

ALLIANCE COUNTY

SACRED HEART HOSPITAL

218-66-1102

ONE OLD SETON DRIVE CLARKSBURG, MD. 21222

FEB 23 1934

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 3 1 2 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELMER WILLIAM SHAW			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20, 1984			2b. HOUR 1:30 p.m.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept. 5 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Koopers Co.	
13a. STATE WV		13b. COUNTY Hampshire		13c. CITY OR TOWN Greenspring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P. O. Box 38 26722	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Shaw				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Robertson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-05-9073		17. INFORMANT Jean Gower,		ADDRESS Romney, WV 26757			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Carcinoma of the pancreas.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. S. SCHWARZ				22e. ADDRESS FROSTBURG PLAZA FROSTBURG, MD 21532			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/23/84		23c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greenspring Hampshire WV	
24. FUNERAL DIRECTOR NAME Keith S. Shaffer				ADDRESS Shaffer Funeral Home, Inc., Romney, WV		25a. DATE REC'D. BY REGISTRAR FEB 24 1984	
						REGISTRAR'S SIGNATURE <i>[Signature]</i>	

COND

THE

THE

TO

THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MARY MIDDLE ELIZABETH LAST SIMMONS			MONTH DAY YEAR February 27, 1984			2b. HOUR 8:10 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR Oct. 18, 1917		66 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		USA				Allegany MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		Memorial Hospital				Retired Practical Nurse			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST George Hedrick			FIRST MIDDLE LAST May E. Matthews			30 Race St. 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			234-22-6966		Margaret Lydinger, Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LIVER FAILURE</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CA. BREAST</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>					DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS		22f. REGISTERAR'S SIGNATURE		
Dr. Qamar Zaman					Memorial Hospital Med. Bldg. Cumberland, MD 21502		2/27/84		
23a. BURIAL, CREMATION, REMOVAL SPECIFY			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			3-1-1984		Restlawn Mem. Gardens		CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
James F. Scarpelli Cumberland, Md. 21502					MAR 2 1984 John Davidson-Randall				

BP

Blank lined paper with two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) OLive P. Simpson			2a. DATE OF DEATH		2b. HOUR	
3. SEX Female			4. RACE White		5. DATE OF BIRTH 9/14/89	
7a. BIRTHPLACE (STATE OR FOREIGN) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Vsg Center		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME James Simpson			15. MOTHER'S MAIDEN NAME Naomi Warnick		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-38-7464ANB		17. INFORMANT ADDRESS Dr. Myron L. Simpson, Cumberland, Md 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Disease (Stroke) 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Secondary to Diffuse Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Iron Deficiency Anemia, Old Age						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-4-83 to 2-6-84 , that (I) (we) lost 1-26-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE W. K. Kight DEGREE 2-7-1984 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 9, 84		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport, All. Maryland
24. FUNERAL DIRECTOR William G. Kight, Cumberland, Maryland				25a. DATE REC'D. BY REGISTRAR 55815 1984 REGISTRAR'S SIGNATURE [Signature]		

BP

William G. Knight, Cumberland, Maryland
Feb. 9, 84 Elliot Cemetery
Westernport, Md. Maryland

20% 8

James Simpson
110-38-3464 Mrs. Byron L. Simpson, Cumberland, Md.
21502
Married

Maryland, Allegheny, Cumberland, Md.
1100 Holland St. 21502
Teacher Retired

West Virginia, USA
Allegheny

3
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified directly.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WARNER C. SMITH			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20, 1984		2b. HOUR 6:35 pm
3 SEX MALE	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR JAN. 5 1902	6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
10 CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Food
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Westernport	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		13e. STREET ADDRESS / ZIP CODE 513 Maryland Ave. 21562	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 108-09-4134		17. INFORMANT ADDRESS Mrs. Beulah Smith Westernport, Md. 513 Maryland Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Myocardial infarction. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. S. SCHWARTZ		22e. ADDRESS FROSTBURG PLAZA FROSTBURG, MD 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/23/84	23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport, Allegany Md.
24 FUNERAL DIRECTOR NAME Wayne Boals		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 27 1984 Julia Davidson-Randall	

BP

● *no longer, hardly*

X

• et •

152

148883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR SCARPELLI FUNERAL HOME 1- STATE REGISTRAR 108 VA. AVE. CUMB.MD.				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				03124 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) GLEN WARD SONNER						20. DATE OF DEATH MONTH DAY YEAR FEBRUARY 24, 1984				2b HOUR 7:45 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 20, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Supervisor			12b. KIND OF BUSINESS OR INDUSTRY Textile		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Allegany 13c CITY OR TOWN Cumberland						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 102 Auburn Ave. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Ward B. Sonner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Baber					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214076915		17. INFORMANT ADDRESS Daughters Ms. Doris J. Poland & Ms. Sandra K. Geiger							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Disseminated Carcinoma</i> <i>1539</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Colon & liver metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>ASCVD</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Raul V. Felipa</i>						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/25/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAUL V. FELIPA, M.D.						22e. ADDRESS 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-27-1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS Cumberland, Md.						25. DATE REC'D. BY REGISTRAR FEB 29 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

BP

STATE OF NEW YORK
IN SENATE
JANUARY 11, 1934

REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
FOR THE YEAR
1933

ALBANY, N. Y.
JANUARY 11, 1934

REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
FOR THE YEAR
1933

Handwritten notes and signatures

RAIL V. BELL, N. Y.
JANUARY 11, 1934

FEB 29 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				03125	
230 E. MAIN STREET ROMNEY, WV 26757				REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		
230 E. MAIN STREET ROMNEY, WV 26757			MARY LEWIS SPANGLER		
2. SEX			2a. DATE OF DEATH MONTH DAY YEAR		
Female			FEBRUARY 3, 1984		
3. RACE			2b. HOUR		
White			12:58 AM		
4. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
April 25 1904			79 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
WV			9. BALTIMORE CITY OR COUNTY OF DEATH		
U.S.A.			ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		
Cumberland			SACRED HEART HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Music Teacher			School		
13a. STATE			13b. COUNTY		
WV			Hampshire		
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Romney			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Mortimer Lewis Smith			Louisa C. Rexrode		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
No			235-56-2838		
17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction 4 days (c) Atherosclerosis		
Donald K. Spangler. P.O. Box 320, Romney, WV			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 3° Heart Block Aspiration Pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
2-3-84		WAYNE SPIGGLE, M.D.		BMG-912 SETON DRIVE, CUMBERLAND, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/5/84		Lahmansville Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME OF CEMETERY OR CREMATORY		23f. DATE REC'D BY REGISTRAR	
Lahmansville Grant WV		Lahmansville Cemetery		FEB 8 1984	
24. FUNERAL DIRECTOR NAME Keith S. Shaffer ADDRESS Romney, WV					



WEEKLY LEADS EXCHANGES

ALBANY COUNTY

CHURCH STREET

NAME SOURCE, M.R.

FEB 8 1964

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lester Lee SPENCER			2a. DATE OF DEATH MONTH DAY YEAR 2/15/84			2b. HOUR 8:00 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10/ 26/ 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Textile	
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cresaptown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Adam Spencer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Tipton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-10-5663			17. INFORMANT ADDRESS Mrs. Mildred Spencer, Cresaptown, Md. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Bronchiectasis; chronic Congestive Heart Failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. H. Hines, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-18-1984		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE La Vale, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.						25. DATE REC'D. BY REGISTRAR FEB 21 1984 REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST RUTH TAYLOR SPERA			MONTH DAY YEAR JANUARY 29, 1984			5:47 A _M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE	White	MONTH DAY YEAR 10 10 05	78 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
Virginia	USA	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	MEMORIAL HOSPITAL		Housewife			In Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			10 North Liberty St. 21502		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Edward Taylor			Mattie Breeden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS		
no			217-10-5401			Mr. Joseph E. Purdham, Cumberland, Md. Son		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Refractory Congestive Heart Failure 2° to		
3209 DUE TO, OR AS A CONSEQUENCE OF		
(b) Meningitis, Gm Positive Bacteremia		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a			
Status Post Abdominal Aortic Aneurysm Resection - Co PD			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-7-83 to 1-28-84, that (I) (we) lost saw the deceased alive on 1-28-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE N. Saheta	DEGREE MD	22c. DATE SIGNED 1-30-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Saheta		22e. ADDRESS Memorial Hospital Cumberland, Md. 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1-31-1984	Hillcrest Burial Park	Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR NAME		25. DATED BY REGISTRAR REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md. 21502		FEB 03 1984 John J. C...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ANTON — SQUILLARI					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1984 11995 P. M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 252 W. Mechanic St. / 21532		
14. FATHER'S NAME FIRST MIDDLE LAST Eugenio --- Squillari			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria --- Ferrari			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) W.W.I				
16b. SOCIAL SECURITY NO. 254-09-9096			17. INFORMANT Eugenio Squillari			ADDRESS 465 Warren Street Cumberland, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for the terminal disease or condition.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction, acute CVA (c) ASCD										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Oct. 28 84 to Feb. 28 84 , that (I) (we) last saw the deceased alive on Feb. 28 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			22b. SIGNATURE Squillari			DEGREE		22c. DATE SIGNED 3-1-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS			22e. MEDICAL BUILDING MEMORIAL HOSPITAL			22f. ADDRESS CUMBERLAND, MARYLAND 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 3/3/84			23c. NAME OF CEMETERY OR CREMATORY Rosedale Chapel Crem.			23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg-Berkeley-Maryland	
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.			25a. DATE REC'D. BY REGISTRAR MAR 12 1984			25b. REGISTRAR'S SIGNATURE John W. Warden-Randall				
202 Greene Street-Cumberland, Maryland 21502										

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

SOWERS FUNERAL HOME				STATE OF MARYLAND	
1- FOR STATE REGISTRAR FROSTBURG, MD 21532				DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
ANNA AGNES STAKEM				FEBRUARY 22, 1984	
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		WHITE		MONTH DAY YEAR	
				12/17/10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
PENNSYLVANIA		U.S.A.		73 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
CUMBERLAND		SACRED HEART HOSPITAL		ALLEGANY COUNTY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS BEFORE ADMISSION)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
MARYLAND ALLEGANY MIDLAND				HOMEMAKER	
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	
ANTON URBAS				THERESA LIKAR	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.	
NO N.A.				219-34-5815	
17. INFORMANT				17. INFORMANT	
				MRS. PATRICIA GARRISON, MIDLAND, MD. 21542	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1749 Exlin Sine Metastatic Carcinoma					
DUE TO, OR AS A CONSEQUENCE OF (b)					
Carcinoma Right Breast					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/21 1984 to 2/22 1984, that (I) (we) last saw the deceased alive on 2/21 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
SIKANDER SANDHIR		M.D.		2/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
SIKANDER SANDHIR, MD		48 TARN TERRACE, FROSTBURG, MD 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		2/25/84		ST. JOSEPH'S CEM	
23d. LOCATION CITY OR TOWN COUNTY STATE		23d. LOCATION CITY OR TOWN COUNTY STATE		23d. LOCATION CITY OR TOWN COUNTY STATE	
MIDLAND ALLEGANY MD.		MIDLAND ALLEGANY MD.		MIDLAND ALLEGANY MD.	
24. FUNERAL HOME OR ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOWERS FUNERAL HOME FROSTBURG		FEB 29 1984		Julia Davidson Randall	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03130			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Allen NMI Stevens				2a. DATE OF DEATH MONTH DAY YEAR 02 24 1984		2b. HOUR 2:10P_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 -- 8-1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MINS 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Layer		12b. KIND OF BUSINESS OR INDUSTRY Brick Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George H. Stevens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Williams		13e. STREET ADDRESS / ZIP CODE Route 2, Box 112 21532			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-5341		17. INFORMANT ADDRESS George W. Stevens, Eckhart, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COPD, CHRONIC BRONCHITIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH NOS.
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (the hospital) attended the deceased from Feb 24 , 19 83 , to Feb 24 , 19 84 , that (I) (we) last saw the deceased alive on Feb 24 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bruce D. Behounek, M.D.				DEGREE MD		22c. DATE SIGNED 2/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE D. BEHOUNEK, M.D.				22e. ADDRESS 912 SEVEN AC, CHAS, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 27 '84		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park Frostburg, Allegany, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 29 1984 Julia Davidson-Randall			

BP _____

INDEX

NOV 24 1944

Stevens

Wife

John

1-10

73

6-10-12

2

Wife

Allegany County

X

U.S.A.

Maryland

Brick Layer Brick Co

Laurel Mount Hospital

Cumberland

House 2, Box 115

X

Frederick

Allegany

Maryland

Williams

Ann

Stevens

H.

George

217-10-2311 George W. Stevens, Newark, Md.

No

Feb. 2, 1944 Frederick, Md. Laurel Mount Hospital, Allegany Co., Md.

FEB 28 1944

Frederick General Home, Frederick, Md.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH03131
REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST CLARENCE		MIDDLE E		LAST STICKLEY		2a. DATE OF DEATH		MONTH 02		DAY 09		YEAR 84		2b. HOUR 12:15PM	
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 02		DAY 05		YEAR 29		6. AGE (IN YEARS LAST BIRTHDAY) 55		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.													
10. CITY OR TOWN OF DEATH CUMBERLAND MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Newspaper													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY ALLEG		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1032 Myrtle St. 21502											
14. FATHER'S NAME FIRST Clarence Leroy		MIDDLE Stickley		LAST		15. MOTHER'S MAIDEN NAME FIRST Laura Virginia													
MIDDLE Johnson		LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes Korean															
16b. SOCIAL SECURITY NO. 213-24-6904		17. INFORMANT ADDRESS Daughters Ms. Colleen Northcraft & Jodie L. Crawford																	
18. CAUSE OF DEATH Enter only one cause per line form (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ruptured abdominal aortic aneurysm</u> 4413 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>emphysema? HPT</u>																			
19a. DATE OF OPERATION 9/26/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Same								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (1) (this hospital) attended the deceased from <u>9/26/84</u> to <u>9/26/84</u> , that (we) last saw the deceased alive on <u>9/26/84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, and (we) did not view the body after death.																			
22b. SIGNATURE Dr. Fred W. Miltenberger		22c. DATE SIGNED 9/26/84																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 122 S. Centre St., Cumberland, Md. 21502																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-13-1948		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE													
24. FUNERAL DIRECTOR NAME James F. Scarpelli		24b. ADDRESS Cumberland, Md. 21502																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13:15

02

STATION

STATION



STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLYDE WILLIAM STUBY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21, 1984		2b. HOUR 9:50 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 22 1917	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Store Room-Glass Works		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 622 Elwood St. 21502
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Stuby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Pisel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-10-7431		17. INFORMANT ADDRESS Mrs. Rossanne Stuby, Cumberland, Md. Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> 4413 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HRS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION 2/21/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured abd. Aortic aneurysm</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> , 19 <u>84</u> , to <u>2-21</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE <u>Dr. Philip Schroeder</u>		DEGREE M.D.		22c. DATE SIGNED 2-21-84	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PHILIP SCHROEDER		22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPRINT)	23b. DATE 2-23-1984	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Harrison Randall</u>	

75
60
35
11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FEB 27

INDEX

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL - THAYER										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 1 19 84		2b. HOUR M 0904	
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 2 22 61		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 61		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 1 19 84		2d. HOUR M 0904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.				7b. CITIZEN OF WHAT COUNTRY? UNITED STATES				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER				12b. KIND OF BUSINESS OR INDUSTRY CONST.	
13a. STATE W. VIRGINIA				13b. COUNTY MINERAL		13c. CITY OR TOWN PAW PAW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS BOX 62		99999	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM - THAYER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL - HELMICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII				16b. SOCIAL SECURITY NO. 236 20 1334		17. INFORMANT ADDRESS MEMORIAL HOSPITAL CUMBERLAND MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Arteriosclerotic Coronary artery Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Francisco Reyes				TITLE (SPECIFY) Deputy				DATE SIGNED 2-1-84					
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes				ADDRESS 900 Seton Dr. Cumberland, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE FEB. 4, 1984		23c. NAME OF CEMETERY OR CREMATORY SAND FORK CEMETERY SAND FORK				23d. LOCATION CITY OR TOWN COUNTY STATE GILMER W. VA.			
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUN'L SER.				ADDRESS 404 DECATUR ST. CUMB. MD.				25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE FEB 06 1984 Joan J. Carver					

1020 08 1 2
1000 00 1 2

THAY

1000

10 30 3 1

WHITE

WHITE STAR

THE GREAT NATIONAL

CHURCHLAND

BOX 82

BOX 82

WHITE STAR

CHURCHLAND

BOX 82

FEB 08 1934
James Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ESTHER V. WARTZACK			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1984			2b. HOUR 12:10 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Allegany County Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21502 Allegany Co. Nursing Home			
14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Mower				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leslie - Brant				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) --			
16b. SOCIAL SECURITY NO. 217-10-5088				17. INFORMANT Ernest F. Wartzack, III - Cumberland, Md.				ADDRESS 817 Mt. Royal Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure 3320 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Severe Parkinson's disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Asx Anteriosclerotic Cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/20/80 , 19 80 , to 2/6 , 19 84 , that (I) (we) last saw the deceased alive on 2/6/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE V. A. Ranjithan				DEGREE				22c. DATE SIGNED 2/6/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA A. RANJITHAN				22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/84		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co., -Md.					
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.				ADDRESS 202 Greene Street-Cumberland, Maryland 21502				FEB 16 1984 John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

SILCOX-MERRITT FUNERAL HOME STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 404 DECATUR STREET CUMBERLAND, MD. 21502 CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN Mary WEISENMILLER				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20, 1984			
3. SEX Female				4. RACE White		2b. HOUR 2:20A M	
5. DATE OF BIRTH MONTH DAY YEAR Jan 16 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS 84		IF UNDER 24 HRS. HOURS MIN. 2:20A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper----		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine King			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-65-3708		17. INFORMANT ADDRESS Paul W. Weisenmiller 532 N. Centre Street Cumberland, Md 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Asphyxia Chronic bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent Resp. infections APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Post operative (Respiratory Infection)							
19a. DATE OF OPERATION 2/11/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RT sided adenoid fac		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 925 BISHOP WALSH ROAD, CUMBERLAND, MD. 21502			
22a. I certify that (I) (this hospital) attended the deceased from 3/15/84 to 2/20/84 , that (I) (we) last saw the deceased alive on 3/15/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Raul V. Felipa		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RAUL V. FELIPA, M.D.		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 23/84		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem, Cumberland Allegany Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service, Cumberland, Md		ADDRESS 404 Decatur St		25. DATE RECD. BY REGISTRAR FEB 23 1984		25a. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____

SHOCKLEY STREET
NEW YORK, N.Y.
FEB 21 1964

FEBRUARY 20, 1964

ATTORNEY ONLY

SHOCKLEY STREET

[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

202 EIGHT HUNDRED FIFTH AVENUE, NEW YORK, N.Y.

DR. ROBERT A. FELLER, M.D.

FEB 23 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLNEY RANSON WHITFIELD			2a. DATE OF DEATH MONTH DAY YEAR Feb. 19, 1984			2b. HOUR 6:00a.m.			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10 CITY OR TOWN OF DEATH Little Orleans		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #1				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Little Orleans		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1 21766	
14. FATHER'S NAME FIRST MIDDLE LAST Mark Jeremiah Whitfield					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Columbia Catherine Morse				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO. 219-14-6890		17 INFORMANT ADDRESS Mrs. Zora S. Whitfield same as 13.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant 4 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from April 26 61 to Feb 19 84 , that (I) (X) lost saw the deceased alive on Jan. 27 84 , and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did) (not) view the body after death.									
22b. SIGNATURE F.B. Thomas III M.D.						DEGREE M.D.		22c. DATE SIGNED 02-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank B Thomas, III, M.D.						22e. ADDRESS Two Tonoloway Hancock, MD 21750			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/22/1984		23c. NAME OF CEMETERY OR CREMATORY Piney Plains U.M.		23d. LOCATION CITY OR TOWN COUNTY STATE Little Orleans Allegany Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Richard J. Moore Hancock MD						25. DATE REC'D. BY REGISTRAR (USE REGISTRAR'S SIGNATURE) FEB 24 1984			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (back) retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000:3

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

FEB 24 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY FRANKLIN WINCE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 14, 1984			2b. HOUR 7:46 PM					
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 16, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? u.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Petroleum			
13a. STATE WV			13b. COUNTY Hampshire		13c. CITY OR TOWN Springfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P. O. Box 88, Springfield, WV 26763		
14. FATHER'S NAME FIRST MIDDLE LAST William Earl Wince				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 721-16-9608		17. INFORMANT ADDRESS Eva M. Wince, P. O. Box 88, Springfield, WV 26757						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ant. wals MI</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2/14</u> 19 <u>84</u> to <u>2/14</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)											
22b. SKINATURE <u>Thaddeus Elder</u>			DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2/15/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. THADDEUS ELDER				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Springfield Hill			23d. LOCATION CITY OR TOWN COUNTY STATE Springfield WV				
24. FUNERAL DIRECTOR NAME Keith S. Shaffer ADDRESS Shaffer Funeral Home, Inc., Romney, WV						25a. DATE REC'D. BY REGISTRAR FEB 21 1984			25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>		

1985

BAND

20%

CHIEF

1985 FEB 1

ZIEGLER FUNERAL HOME 1 - FOR STATE REGISTRAR HYDMAN, PA.				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03138			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CURTIS CLIFTON WITT				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16, 1984				2b. HOUR 10:30 PM			
3. SEX Male		4. RACE Caus.		5. DATE OF BIRTH MONTH DAY YEAR 02/26/1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal			
13a. STATE Pa.		13b. COUNTY Somerset		13c. CITY OR TOWN Wellersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 121 / 15504		99999	
14. FATHER'S NAME FIRST MIDDLE LAST Noah Witt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Troutman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 01 6738		17. INFORMANT ADDRESS Emma Witt, Box 121, Wellersburg, Pa. 15504					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Glucose-junctional shock</u> 2028 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>severe sepsis - Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>for failure - aggressive</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-22-</u> 19 <u>84</u> , to <u>2-16</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-16</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John Mehanne</u>				DEGREE M.D. - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-17-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA M.D.				22e. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/19/84		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale, Allegany, Md.			
24. EXAMINER'S NAME Harvey H. Ziegler				ADDRESS Hydman, Pa. 15545		25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

10-12 P.M. 1964

CLIP

CLIP

CLIP

CLIP

CLIP

CLIP

CLIP

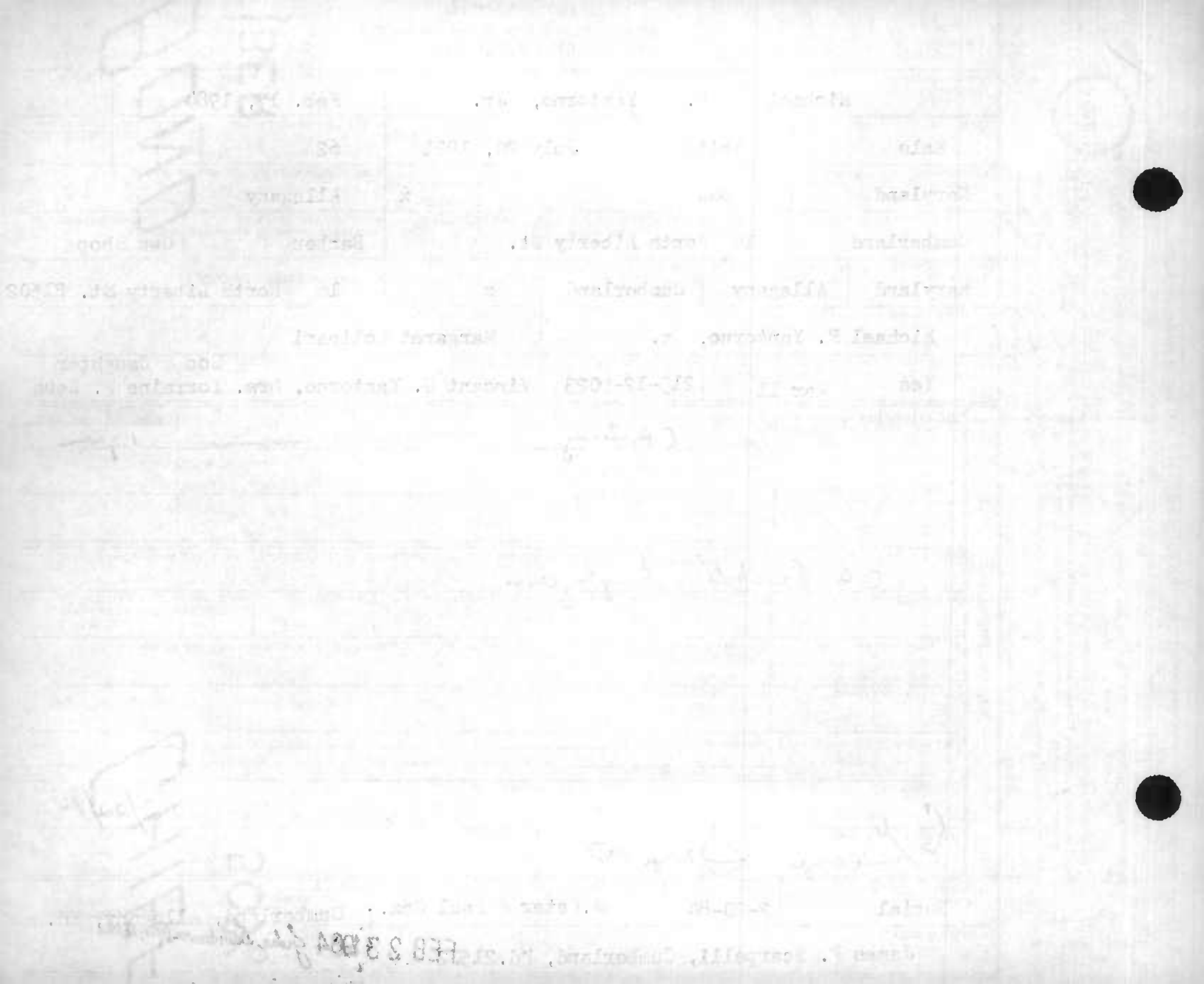
CLIP

FEB 23 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Michael R. Yantorno, Jr.		Feb. 17, 1984		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Male	White	July 20, 1921	62	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	16 North Liberty St.		Barber		Own Shop
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland	Allegany	Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
Michael F. Yantorno, Sr.		Margaret Molinari		16 North Liberty St. 21502	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS			
Yes	War II	Son & Daughter Vincent G. Yantorno, Mrs. Lorraine F. Neus			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1629 IMMEDIATE CAUSE (a) CA Lung					1 year
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER DECEASED CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
CA Prostate, Emphysema					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK AT WORK		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
George Dray MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
George Dray MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	2-20-84	SS. Peter & Paul Cem.	Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR		25. DATE REPORT MADE			
James F. Scarpelli, Cumberland, Md. 21502		FEB 23 1984			



RECEIVED FEB 23 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03140

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN EDWARD YOST			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 9, 1984			2b. HOUR 10:22 PM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 07 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian	
						12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Kilborn Yost		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Albright		13e. STREET ADDRESS / ZIP CODE 21502 Booth Towers Apt. 609			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-5197		17. INFORMANT ADDRESS Gertrude Yost - same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) <u>Massive CVA (thrombotic)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> 19 <u>84</u> to <u>2/9</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thaddeus Elder		22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/12/84		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany MD	
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

